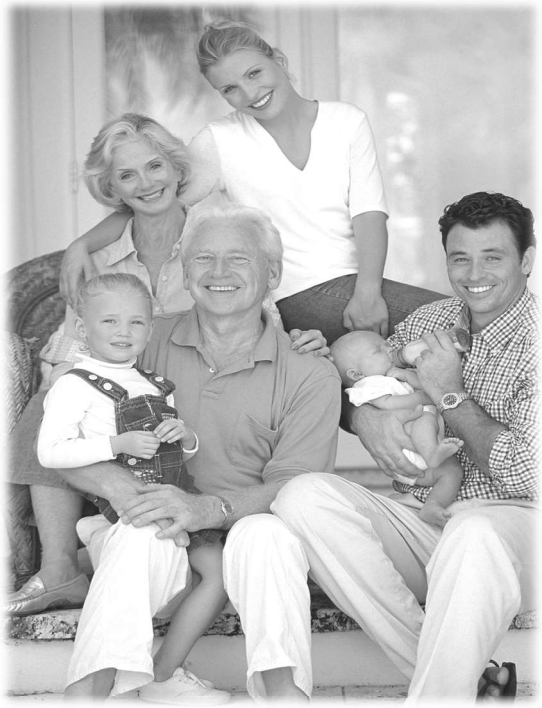
Member Handbook



BlueLincs

Blue Cross and Blue Shield of Oklahoma

Schedule of Benefits – Plan D

A. Physician Services

The benefits listed below will be provided to Members only when Medically Necessary Covered Services are performed, prescribed, directed or Preauthorized by the Primary Care Physician the Member has selected.

		COPAYMENT
1.	Physician services, office, Hospital or home visits	$10 per visit*
2.	Specialist care and consultation	$10 per visit*
3.	Diagnostic, radiology, ultrasound and laboratory procedures	NO EXTRA CHARGE
4.	Immunizations	NO EXTRA CHARGE
5.	Periodic physical examinations	NO EXTRA CHARGE
6.	Vision and hearing screening to age 19 (one per year)	NO EXTRA CHARGE
7.	Well baby care	NO EXTRA CHARGE
8.	Allergy testing	NO EXTRA CHARGE
9.	Allergy treatment and allergy serum	50% of allowable charge**
10.	Services of a surgeon and an anesthesiologist, including surgical procedures in Physician offices	NO EXTRA CHARGE
11.	Anesthesia services associated with any Medically Necessary dental procedure when provided to a Member who is severely disabled or eight years of age or under; and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care	NO EXTRA CHARGE
12.	Injections or infusions administered in the office	NO EXTRA CHARGE

B. Inpatient Hospital and Skilled Nursing Facility Services

The benefits listed below will be provided at a Participating Hospital or Participating Skilled Nursing Facility during a confinement for which Medically Necessary room and board charges are made and which is Preauthorized by the Primary Care Physician the Member has selected.

		COPAYMENT
1.	Inpatient Hospital Services including:	$50 per day*, per admission
	a. Unlimited number of days in a semiprivate room Private room is also covered if determined Medically Necessary and prescribed in advance by the Participating attending Physician	for first 5 days, then NO CHARGE
	b. Intensive Care/Coronary Care	
	c. Use of operating room and special treatment rooms	
	d. Drugs and medications	
	e. General nursing and ancillary services	
	f. Administration of blood, blood plasma and blood derivatives	
	g. X-ray, laboratory and diagnostic services	
	h. Special duty nursing when Medically Necessary and prescribed by the Member's Primary Care Physician or Specialist (20 visit limit per Calendar Year)	
	i. Hospitalization for a Member who is severely disabled or eight years of age or under; and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care	
2.	Nursery newborn services	$50 per day*, per admission for first 5 days, then NO CHARGE
3.	Skilled Nursing Facility/Inpatient rehabilitation (limited to 100 days per Calendar Year, 300 day lifetime maximum)	$50 per day* per admission for first 5 days, then NO CHARGE

C. Outpatient Hospital or Facility Services

			COPAYMENT
1. Surgery	2. Diagnostic procedures	3. Injections or infusions	NO CHARGE
4. Radiation therapy	5. Laboratory procedures	6. Dialysis	
7. Other therapies and procedures			

D. Maternity Services

		COPAYMENT
1.	Physician services, including prenatal and postnatal care	$10 for initial visit only*, then NO CHARGE
2.	Diagnostic, radiology, ultrasound and laboratory procedures	NO EXTRA CHARGE
3.	Hospital Services	Same as other Hospital Services

E. Outpatient Urgent Care

COPAYMENT

1. Urgent services, supplies and medical treatment, whether in the Service Area or out of the Service Area, provided in an emergency room — $75 per visit*±
2. Participating minor emergency care centers — $50 per visit*

Urgent Care is defined as treatment for an unexpected illness or injury that is not an emergency, but which is severe or painful enough to require treatment within 24 hours. Examples include, but are not necessarily limited to: lacerations, high fever, vomiting and diarrhea, pulled muscles, or other similar illnesses or injuries.

If a Member needs Urgent Care, a call must be made to the Member's BlueLincs HMO Primary Care Physician to explain the illness or injury. The Physician may instruct the Member in a method of home care, ask the Member to come to the office or advise the Member to go to a minor emergency care center or emergency room. Use of the minor emergency care center or emergency room for Urgent Care which is not Preauthorized by the Member's Primary Care Physician is not covered. ***All follow-up care must be provided or prearranged through the Member's Primary Care Physician.***

F. Outpatient Emergency Care

COPAYMENT

1. Emergency services, supplies and medical treatment, whether in the Service Area or out of the Service Area, provided in an emergency room — $75 per visit*±
2. Participating minor emergency care centers — $50 per visit*

BlueLincs HMO defines Emergency Care as treatment for any injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in: a) serious jeopardy to the Member's health; b) serious impairment to bodily function; or c) serious dysfunction of any bodily organ or part. Examples include, but are not necessarily limited to: major trauma, loss of consciousness, suspected heart attacks, severe abdominal or chest pains, fractures, uncontrolled bleeding, burns, attempted suicide or poisonings.

If a Member needs Emergency Care, the Member should seek care from the nearest appropriate facility. ***All follow-up care required after an emergency must be provided or prearranged through the Member's Primary Care Physician.***

G. Out of Area Benefits

If the Member needs Urgent Care and is traveling outside the BlueLincs HMO Service Area, but within the state of Oklahoma, follow the "Urgent Care" procedures described in Section E.

If the Member needs Urgent Care and is traveling outside the state, call 1-800-810-BLUE (1-800-810-2583) or log on to www.bcbsok.com to access the BlueCard® Program's provider finder 24 hours a day.

If a Member needs Emergency Care while traveling outside the BlueLincs HMO Service Area, the Member should seek care from the nearest appropriate facility. See examples of medical emergencies under Section F. ***All follow-up care required after an emergency must be provided or prearranged through the Member's Primary Care Physician.***

H. Mental Illness Services

Benefits are provided only when Medically Necessary Covered Services are performed, prescribed, directed or Preauthorized by the Primary Care Physician the Member has selected or Preauthorized by BlueLincs.

COPAYMENT

1. Outpatient benefits include service in the office of a psychiatrist, clinical psychologist or psychiatric social worker for visits of one hour or less with a maximum of 20 visits per Calendar Year for short-term evaluation and crisis intervention including counseling for mental health problems connected with the abuse of drugs or alcohol (one intensive Outpatient session can be exchanged for two visits of one hour or less). — 50% of allowable charge**
2. Inpatient benefits, including Physician services and Hospital Services, are available with a maximum of 7 Inpatient days per Calendar Year (two partial days can be exchanged for one Inpatient day). Residential care is not covered. — 50% of allowable charge**

I. Alcohol and Drug Abuse Services

Benefits are provided only when Medically Necessary Covered Services are performed, prescribed, directed or Preauthorized by the Primary Care Physician the Member has selected.

COPAYMENT

1. Outpatient emergency detoxification for alcoholism or drug overdose when Medically Necessary — **Outpatient** emergency room $75 per visit*±
2. Inpatient detoxification — **Inpatient** Hospital 20% of allowable charge**

J. Special Services

COPAYMENT

1. Skilled Home Health Care Services provided by a Participating Home Health Care Agency, when recommended by the Member's Primary Care Physician and approved in advance by the BlueLincs Medical Director, but not including meals, housekeeping and personal convenience items (coverage for physical therapy, occupational therapy and speech therapy provided at home is described in Section J.7). — NO CHARGE
2. Voluntary family planning services when referred by the Member's Primary Care Physician. Services must be performed by a Participating Provider. — NO CHARGE

J. Special Services, continued **COPAYMENT**

3. Services for diagnosis and treatment of infertility when referred by the Member's Primary Care Physician. Services must be performed by a Participating Provider. 50% of allowable charge**
4. Dental services to sound natural teeth, including replacement of such teeth, required due to accidental injuries. NO CHARGE
5. DME, including casts, splints, crutches, prostheses, oxygen supplies or other appliances/supplies used exclusively for medical treatment ($1000 maximum benefit per Calendar Year). 20% of allowable charge**
6. Ambulance service for Medically Necessary emergency transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured to the closest facility that can provide Covered Services appropriate to the Member's condition. NO CHARGE
7. Physical therapy, occupational therapy and speech therapy when prescribed by the Member's Primary Care Physician for conditions which are judged subject to significant improvement through short-term therapy and provided in an outpatient or home setting (maximum 60 consecutive calendar days per condition). 20% of allowable charge-per visit**
8. Audiological services and hearing aids for Members up to age 18, limited to every 48 months for each hearing-impaired ear; however, up to four additional ear molds are available for children up to two years of age. Hearing aids must be prescribed, filled and dispensed by a licensed audiologist. NO CHARGE
9. Wigs or other scalp prostheses which are Medically Necessary for the comfort and dignity of the Member, and which are required due to hair loss resulting from radiation therapy or chemotherapy ($150 maximum benefit per Calendar Year). NO CHARGE

K. Annual Out-of-Pocket Maximum

Annual Out-of-Pocket Maximum, per Member, per Calendar Year $1,000

This Out-of-Pocket Maximum does not include Copayments for prescription drugs, certain mental health services, alcohol and drug abuse services, non-authorized services performed by a non-participating Provider, Self-Referral Services, supplemental services or noncovered services.

Family Coverage – After three covered family Members have reached the Out-Of-Pocket Maximum in one Calendar Year, eligible expenses for those and other covered family Members will be paid in full during the remainder of that year.

L. Exclusions and Limitations.

The following services or procedures are not covered by BlueLincs HMO:

1. Services BlueLincs determines are not Medically Necessary.
2. Non-emergency services that are not authorized by the Member's Primary Care Physician.
3. Expenses incurred while not covered by this Plan.
4. Services which BlueLincs determines are Experimental/Investigational in nature.
5. Any condition to the extent benefits are provided under Medicare or any other governmental program.
6. Procedures, services and supplies related to sex transformation.
7. Physical examinations for obtaining or for continuing employment, insurance, government licensing, flight, camp, school, athletics or immunization for international travel.
8. Services (except artificial insemination) related to conception by artificial means, including in vitro fertilization and embryo transfers or reversal of voluntary, surgically-induced sterility.
9. Cosmetic surgery or complications resulting therefrom, including surgery to improve or restore personal appearance, unless: a) needed to repair conditions resulting from an accidental injury; or b) for the improvement of the physiological functioning of a malformed body member (including cleft lip and cleft palate), except for services related to Orthognathic Surgery, osteotomy, or any other form of oral surgery, dentistry or dental processes to the teeth and surrounding tissue. In no event will any care and services for breast reconstruction or implantation be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy or other Medically Necessary procedure.
10. Hearing aids, except as specified for Members under age 18.
11. Supportive devices for the feet, except for podiatric appliances for prevention of complications associated with diabetes.
12. Repair and/or replacement of Durable Medical Equipment which is lost, damaged or destroyed due to improper use or abuse.
13. Refractions, including lens prescriptions, corrective eyeglasses and frames or contact lenses (including the fitting of the lenses) except as may be specifically provided for in a supplemental Vision Care Schedule of Benefits. Refractive surgery is excluded.
14. Expenses for or related to transplantation of donor organs, tissues or bone marrow, except as may be specifically provided for in the Group Master Agreement. All transplants must be authorized in advance by BlueLincs.
15. Collection and storage of blood products or tissues.
16. Custodial Care, respite care, homemaker services, domiciliary or convalescent care.
17. Personal convenience or comfort items or services.
18. Care provided outside the Service Area if the need for care could have been foreseen before departing the Service Area.
19. Medical and Hospital costs resulting from a normal, full-term delivery of a baby outside of the BlueLincs Provider Network.
20. Services, supplies or charges related to Inpatient treatment for any non-covered dental procedure, except that coverage shall be provided for Hospital Services, ambulatory surgical facility services and anesthesia services associated with any Medically Necessary dental procedure when provided to a Member who is severely disabled or eight years of age or under; and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.

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*+ This Copayment can only be waived if a Member is admitted to the Hospital through an emergency room visit.

* Copayments are to be collected at the time service is rendered or at the convenience of the Provider.

** Allowable charge is the billed charge less any negotiated Provider discount.

L. Exclusions and Limitations, continued

21. Orthognathic Surgery, osteotomy of the mandible or maxillae, correction of malocclusion, correction of malpositions of the teeth, and items or services for care, treatment, filling, removal, replacement or artificial restoration of the alveolar processes, gums, jaws or associated structures except for: a) the treatment of accidental injury to the jaw, sound natural teeth, mouth or face; or b) for the improvement of the physiological functioning of a malformed body member, including cleft lip and cleft palate.
22. Treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, physical therapy and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
23. Inpatient or Outpatient care which is necessitated in whole or in part by a non-covered condition or service.
24. Medical supplies such as dressings, antiseptic, needles, syringes (except for diabetics) and other over-the-counter items.
25. Drugs, including prescription drugs, except as may be covered by a supplemental Prescription Drug Schedule of Benefits. Inpatient drugs are covered. Insulin and diabetic supplies for diabetics are covered.
26. Surgical procedures, services or charges related to weight reduction.
27. Dietary control programs, including but not limited to the following: the dietary control program; prescription or non-prescription drugs, or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; or any other treatment.
28. Provision of human or synthetic growth hormone or Outpatient provision of total parenteral nutrition, hyperalimentation unless authorized in advance by BlueLincs (administration and supervision are covered). Nutritional products, including supplements or replacements, for enteral or oral intake are excluded.
29. Evaluation and treatment of mental retardation (except for medical treatment) or evaluation and treatment of learning disabilities, including attention deficit disorder and behavioral and conduct disorder. This exclusion shall not apply to the following Medically Necessary services: a) physicians' services (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Members age 19 and under; or b) prescription drug therapy (provided the Agreement includes supplemental benefits for Prescription Drugs) for treatment of ADD/ADHD in Members age 19 and under.
30. Psychological testing when not Medically Necessary to determine the appropriate treatment of a short-term psychiatric condition or psychological testing or therapy when it is court ordered or as a condition of parole or probation.
31. Medical Services for which the Member declines to authorize release of information to BlueLincs.
32. Work or exercise related equipment.
33. Genetic analysis, including DNA studies, chromosomal banding and gene identification studies, except when there are signs and/or symptoms of an inherited disease in the affected individual, the diagnosis would remain uncertain without such testing, the testing will impact the care and management of the affected individual and is authorized in advance by BlueLincs. BlueLincs will cover amniocentesis for use only in women age 35 or older OR for those women with a family history of inherited genetic disorders. Gene therapy is excluded.
34. Administrative fees for dialysis.
35. Physician standby services.
36. Services not specifically named in the preceding Schedule of Benefits.
37. Contraceptive devices including diaphragms and surgically implanted contraceptive devices (intrauterine devices and intradermal devices).
38. Equipment not used exclusively for medical treatment such as: air-cleaning machines or air-filtering systems recommended for allergies; bed wetting alarm monitor devices; breast pumps; earplugs; hot tubs; hand-held shower attachments. Other items may be excluded, as well.
39. Elective abortions.
40. Health care services provided by an immediate family member.
41. Telephone, email or other electronic consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
42. Family or marital counseling.
43. Hippotherapy, equine assisted learning, or other therapeutic riding programs.
44. Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
45. Ductal lavage of the mammary ducts.
46. Extracorporeal shock wave treatment, also known as orthotripsy, using either a high- or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
47. Orthoptic training.
48. Thermal capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
49. Transcutaneous electrical nerve stimulator (TENS).
50. Drug and alcohol treatment that is not rendered in a Hospital or in an appropriate outpatient setting by a psychiatrist, psychologist, licensed clinical social worker or person with a master's degree in social work.
51. Services rendered by licensed professional counselors, marital and family therapists or counselors, or licensed drug and alcohol counselors.
52. Services rendered by midwives.
53. Refer to the Member Handbook or Group Master Agreement for the terms and conditions that apply to work related illness or injuries.

When you join BlueLincs, you select a Primary Care Physician for yourself and each Member of your family. Your Primary Care Physician will coordinate your medical care needs and refer you to his or her affiliated Specialists. When you choose a Primary Care Physician, you are also choosing your Specialists.

BlueLincs

Blue Cross and Blue Shield of Oklahoma

Vision Care Schedule of Benefits

- **One routine vision exam (including refractions, eye drops when necessary and glaucoma testing for at-risk adults) per member, per 12-month period.**
  $10 COPAYMENT PER EXAM

- **Frames, lenses and contact lenses (excluding disposable lenses). Frames, lenses and contact lenses must be purchased from a participating provider.**
  20 PERCENT DISCOUNT

All vision services listed above must be received from a Participating Vision Provider.
No authorization from the Primary Care Physician is required.

Exclusions and Limitations

The BlueLincs Vision Care program does **not** cover the following:

- Routine vision exams received from a nonparticipating provider.
- Services and supplies in connection with special procedures such as orthoptics, vision training or in connection with medical or surgical treatment of the eye.
- Follow-up care for contact lenses.
- More than one routine eye exam per covered individual, per 12-month period.
- Lens options such as tinting, bifocals or trifocals.

This product description is intended to be a summary of benefits available through the program and as incorporated into the Group Master Agreement. In the event of any inconsistencies between language in this summary and the Group Master Agreement, the terms in the Agreement shall control.

BlueLincs

Blue Cross and Blue Shield of Oklahoma

A Wholly Owned Subsidiary of Blue Cross and Blue Shield of Oklahoma, a Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

Schedule of Benefits - Prescription Drug

Per-prescription Copayment/Coinsurance

Generic Drugs - $12 Copayment or 30% Coinsurance (whichever is greater)*

The Copayment/Coinsurance will be applied as follows:

Quantity Dispensed	Copayment/Coinsurance
1 to 30 days	30% of allowable charges with a $12 minimum
31 to 60 days±	30% of allowable charges with a $24 minimum
61 to 90 days±	30% of allowable charges with a $36 minimum

Preferred Drugs - $25 Copayment*

The Copayment will be applied as follows:

Quantity Dispensed	Number of Copayments
1 to 30 days	1 Copayment
31 to 60 days±	2 Copayments
61 to 90 days±	3 Copayments

Non-Preferred Brand Drugs - $25 Copayment or 30% Coinsurance (whichever is greater)*

The Copayment/Coinsurance will be applied as follows:

Quantity Dispensed	Copayment/Coinsurance
1 to 30 day	30% of allowable charges with a $25 minimum
31 to 60 days±	30% of allowable charges with a $50 minimum
61 to 90 days±	30% of allowable charges with a $75 minimum

Benefits

- Prescription Drugs must be drugs that are required by federal and state law to be dispensed only by prescription.
- Benefits are provided for Prescription Drugs dispensed for a Member's use when recommended by and while under the care of a Participating Provider (or Medical Group Participating Provider), provided such care and treatment is Medically Necessary and is a Covered Service in this Schedule of Benefits.
- Benefits for Prescription Drugs are available to the Member only:
  1. In accordance with a Prescription Order.
  2. After the Member has incurred charges equal to the Copayment or Coinsurance for each Prescription Order. If the charge for the Member's prescription is *less* than the Copayment, the Member will pay the lesser amount.
  3. Dispensed by a Participating Retail Pharmacy (except in Emergency situations).
- Benefits include:
  1. Injectable insulin, insulin syringes and blood glucose treatment strips.
  2. Oral contraceptives, regardless of Medical Necessity (each month's supply of oral contraceptives is considered a separate prescription).
  3. Self-injectables will be reimbursed as any other Prescription Drug. Injectable drugs purchased from a Physician and administered in his/her office are not considered a self-injectable for purposes of this Schedule of Benefits.

Copayment for Prescription Orders is governed by the BlueLincs formulary. A listing of Preferred Brand Drugs is available from Member Services or on the Blue Cross and Blue Shield of Oklahoma Web site, located at **www.bcbsok.com**.

Copayments are to be collected by the Participating Retail Pharmacy at the time the Prescription Order is dispensed. Copayments do not apply to the Member's Out-Of-Pocket Maximum specified in the Member's Schedule of Benefits.

Continued on back

Limitations on Benefits

- **Maximum Quantities:** Benefits will be provided for Prescription Drugs dispensed in the following maximum quantities:
  1. Up to a 30-day supply or 100 unit doses (whichever is less) for one (1) single copayment; or
  2. Up to a 60-day supply or 200 unit doses (whichever is less) for drugs designated by BlueLincs HMO as maintenance legend Prescription Drugs (excludes oral contraceptives) for two (2) copayments.§
  3. Up to a 90-day supply or 300 unit doses (whichever is less) for drugs designated by BlueLincs HMO as maintenance legend Prescription Drugs (excludes oral contraceptives) for three (3) copayments.§

  Prescription Drug benefits are not provided under this Schedule of Benefits for charges for Prescription Drugs dispensed in excess of the above stated amounts.
- Benefits will not be provided for a Prescription refill until 75 percent of the prescribed dosage has been used.
- In order for a Prescription Drug obtained from a Non-Participating Pharmacy to be covered, the following criteria must be met:
  1. The Member is outside the Service Area and the Physician orders the Prescription Drug to treat a covered Emergency condition (as determined by BlueLincs HMO); or
  2. The Member's Primary Care Physician orders the immediate use of a Prescription Drug due to a Medical Necessity, and no Participating Retail Pharmacy is open.

  Benefits are limited to a three-day supply per Prescription Order in the case of Prescription Drugs for Emergency conditions. BlueLincs HMO reserves the right to determine what constitutes an Emergency or Medical Necessity. To receive reimbursement for Emergency prescriptions, the Member must send BlueLincs the pharmacy receipt showing payment, name of the Prescription Drug, itemized cost, and a written statement regarding the circumstances of the Emergency.

Certain drugs require the Member to receive Preauthorization (Precertification) in order for benefits to be provided under the Group Master Agreement. Precertification may be requested by the Member or Physician before the drug is dispensed. BlueLincs may deny coverage for these drugs or specify that a limited quantity of the drugs be dispensed.

Exclusions

No benefits will be provided under the Prescription Drug Benefit Supplement for:

- Human growth hormones
- Contraceptive devices
- Prescription vitamins (except prenatal vitamins taken during pregnancy)
- Appetite suppressants or other agents used for weight loss
- Smoking cessation products or devices
- Drugs used for treatment of learning disabilities, including Attention Deficit Disorder and behavioral and conduct disorders (e.g. Ritalin, Adderall)
- Infertility drugs
- Needles and syringes (except insulin syringes)
- Non-prescription drugs (includes over-the-counter items)
- Medications or devices used to retain or alter hair growth
- Drugs not FDA approved
- Drugs used for male erectile dysfunction
- Drugs used for cosmetic purposes
- Medications used for elective abortions

This product description is intended to be a Schedule of Benefits available through this program and is incorporated into the Group Master Agreement. In the event of any inconsistencies between the language in this Schedule of Benefits and the Group Master Agreement, the terms in the Group Master Agreement shall control.

* Copayments are to be collected at the time service is rendered or at the convenience of the Provider.

± Maintenance drugs only

† BlueLincs maintains a list of Preferred Drugs that have been reviewed and approved by a committee of Participating Physicians and pharmacists. Periodic changes to this list of preferred drugs are made by this committee.

§ Food and Drug Administration determines drugs eligible for 60- or 90-day prescriptions.

Table of Contents

Certificate

This Member Handbook is issued according to the terms of your Group Health Plan (the "Plan"). It contains the principal provisions of the Group Master Agreement (the "Agreement"). BlueLincs HMO (also called BlueLincs, we, us or our) provides only the benefits specified in the Agreement and the Schedule of Benefits issued with this Member Handbook.

Only Members are entitled to benefits from BlueLincs, and they may not transfer their rights to benefits to anyone else. Benefits for Covered Services under the Plan will be provided only for services and supplies that are specified in this Member Handbook.

You will notice that some words or phrases start with a capital letter. Those terms may have a special meaning in the Agreement and your Member Handbook. Be sure to check the Definitions section at the end of this Handbook for an explanation of these terms. Failure to read or understand the contents of this Handbook is not a basis for appeal of any BlueLincs decision regarding the misuse of the Plan or failure to follow BlueLincs guidelines. In the event of conflict between the Agreement and this Handbook, the terms of the Agreement shall prevail.

Your Group has contracted with BlueLincs to provide the benefits described in the Agreement. BlueLincs certifies that all persons who have met the four requirements below are covered by the Agreement:

- applied for coverage under the Agreement;
- paid for the coverage;
- satisfied the eligibility conditions specified in the Eligibility, Enrollment, Changes and Termination section; and
- been approved by BlueLincs.

Beginning on your Effective Date, we agree to provide you the benefits described in the Agreement.

BlueLincs HMO
Welcomes You

Congratulations! You have selected a special kind of health care coverage from BlueLincs.

About BlueLincs

BlueLincs is a wholly owned subsidiary of Blue Cross and Blue Shield of Oklahoma, a company that has been providing health care protection to Oklahomans for more than 60 years.

BlueLincs directly contracts with health care Providers who provide a comprehensive range of health care services, rather than simply reimbursing you after you have Incurred medical expenses.

The key element in meeting your health care needs is to establish a strong relationship between you and your Primary Care Physician (PCP). It is important that you contact your PCP whenever you need medical care – including routine health care, referrals to specialists, hospitalization and Urgent and Emergency Care. Otherwise, you may incur expenses that will not be covered by BlueLincs.

There are five documents that are necessary to understand your rights and responsibilities as a Member. Each should be carefully reviewed and retained for future use.

- **Member Handbook**

  This Member Handbook is your source of information about how your Plan works.

- **Plan Schedule of Benefits**

  The Schedule of Benefits will tell you what your Copayments and/or Deductibles are for each type of service and what services are covered.

- **Supplemental Riders, if applicable**

  Because of some state or federal laws or the special needs of your Employer, provisions called "riders" may be added to your Member Handbook. Be sure to check for a "rider." It changes provisions or benefits in the Agreement and your Member Handbook.

- **Provider Directory**

  This contains a listing of all Participating PCPs, Specialists and Hospitals.

- **ID Card(s)**

  You will receive an identification card (ID card) to show Providers of care when you need to use your coverage.

  Your own personal ID number is on your card. **Each of your covered Dependents will receive an ID card showing a separate ID number.**

  Carry your ID card at all times and present it to Providers of care when you need services. If it gets lost, call BlueLincs Member Services at 1-800-580-6202 to request a new card. Any time you have a benefit change or change your PCP, a new ID card will be mailed to you.

  Legal requirements govern the use of your ID card. You cannot let anyone else use your ID card. Doing so may result in immediate termination of your coverage. You may appeal by following the Member Complaints and Appeals procedures described in this Handbook.

How to Get Answers to Your Questions

You usually will be able to answer your health care benefit questions by referring to this Member Handbook. If you need more help, just call BlueLincs Member Services at 918-561-9933 in Tulsa or 405-841-9777 in Oklahoma City, or our toll free number 1-800-580-6202.

Your Rights and Responsibilities as a BlueLincs Member

- As a BlueLincs Member, you have certain rights and responsibilities. Among them are:

- The right to receive information about BlueLincs, its services, its practitioners and Providers, and Members' rights and responsibilities.

- The right to receive or have arranged by your BlueLincs Provider all Medically Necessary care covered under your benefit package.

- The right to considerate and courteous care with respect for personal privacy.

- The right to be informed in clear, understandable language about your diagnosis, treatment options and prognosis.

- The right to be involved in decision-making concerning your treatment.

- The right to candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.

- The right to confidentiality of information concerning your treatment.

- The right to know the identity of all persons involved in your care.

- The right to refuse treatment and to be told of the medical consequences.

- The right to be informed of research projects involving your care and the right to refuse participation in them.

- The right to file a complaint, grievance or appeal and be given due process.

- The right to designate an authorized representative to act on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination.

- The responsibility to work with your PCP in maintaining a satisfactory Physician-patient relationship.

- The responsibility to contact your PCP for authorization of care when you choose to use your benefits.

- The responsibility to comply with the prescribed medical treatment.

- The responsibility to provide complete health status information for accurate diagnosis and appropriate treatment.

- The responsibility to keep appointments for care and give required cancellation notice.

- The responsibility to read and understand all materials concerning your health benefits.

- The responsibility to notify your Employer and BlueLincs of any other Group coverage you have, and to cooperate with BlueLincs in its coordination of benefits efforts.

- The responsibility to pay any required portion of your premium, as well as Copayment and/or Deductible amounts required under your benefits coverage.

- The responsibility to call BlueLincs whenever you are unsure of procedures or covered benefits (1-800-580-6202).

How BlueLincs Works

Your Primary Care Physician (PCP)

- **Choosing Your PCP**

  When you Enroll, you will receive at no charge a directory of BlueLincs Providers. You will choose a PCP from the Provider Directory. Your PCP is your personal health care manager and will share with you the responsibility for your total health care.

  You must choose a PCP when you Enroll and include your choice on your application. If you do not designate a PCP, we will try to contact you. If we cannot reach you, BlueLincs will select a PCP for you.

  When choosing your PCP, there may be information you need to know, such as an address, phone number and specialty. This information, including detailed maps to the doctor's office, can be found on our Web site (www.bcbsok.com), or you may call Member Services.

  The BlueLincs Provider network is subject to change, and the availability of any Provider cannot be guaranteed.

  You **MUST** contact your PCP whenever you need any medical care. When your PCP is out of the office, the doctor's staff will help you find another Physician or you may call Member Services. BlueLincs provides benefits only for care received from or approved by your PCP, with the exception of Emergency Care.

- **Changing Your PCP**

  You may change your PCP up to four times per year. To change your PCP, call or write Member Services. **Requests must be received no later than the 20th day of the month to be effective on the first day of the following month.** Changes are subject to PCP availability. All referrals, Precertifications and Prescription Orders made by your former PCP are void as of the Effective Date of your PCP change. Your new PCP is responsible for your care as of the Effective Date. You should schedule a welcome visit with your new PCP to discuss your health care needs as soon as possible.

- **Medical Group Networks**

  When you choose your PCP, you are also choosing your Medical Group Network. This includes Specialists, Hospitals and other health care professionals. Many of BlueLincs' PCPs are with a specific Medical Group or clinic. If your PCP is with a Medical Group or clinic, your PCP will coordinate referrals through his or her Managed Care Committee.

Independent Contractor Relationships

The relationships between BlueLincs and its Participating Providers are independent contractor relationships. These individuals, institutions or agencies are not agents or employees of BlueLincs. Neither BlueLincs nor any of its employees is an employee or agent of any Participating Provider.

PCPs maintain the Physician-patient relationship with Members and are solely responsible to Members for all Covered Services that are rendered by them.

Neither you nor your Employer is an agent or representative of BlueLincs, its agents or employees, or any Participating Provider or other person or organization with which BlueLincs has made or shall make arrangements for Covered Services under the Agreement.

If you have any questions about how your Physician or other health care Providers are compensated for providing you services, BlueLincs encourages you to discuss this issue with your Physician or other Provider.

Members are subject to all rules and regulations of each Hospital and any other Provider that provides benefits for Covered Services.

Physician Appointments

You will need to make an appointment for each visit to your PCP or Specialist as approved by your PCP.

If you need to cancel an appointment, please do so 24 hours in advance. This is a courtesy to your doctor and other patients who may need that available appointment.

BlueLincs is not responsible for any Physician charges resulting from a missed appointment when a Member fails to cancel a scheduled appointment.

Types of Covered Care

- **Routine Care**

  When you need routine care, contact your PCP's office for an appointment. Show your ID card and pay any Copayments at the time of the visit. Routine care (such as periodic physicals and childhood immunizations) is not covered when Members are outside the BlueLincs Service Area. Routine care includes, but is not limited to:

  - Newborn and well child care;
  - Periodic physical exams;
  - Childhood immunizations (as recommended by the Centers for Disease Control);
  - Vision and hearing screening to age 19;
  - Screening for cervical cancer (annual pap smear);
  - Screening for breast cancer (mammography from age 35);
  - Screening for colorectal cancer (from age 50);
  - Screening for prostate cancer (PSA from age 50);
  - Flu vaccine for Members who are 50 years or older OR when it is Medically Necessary for Members under age 50 with chronic illness such as diabetes, heart disease, moderate to severe asthma, renal failure, cancer or AIDS.

- **Specialty Care**

  All specialty care must be authorized in advance by your PCP. If you visit a Specialist or other health care Provider without your PCP's authorization, you will be responsible for all charges.

  The BlueLincs Provider network is subject to change, and availability of any Provider cannot be guaranteed.

  When visiting BlueLincs Participating Specialists, be sure to show your ID card and pay any required Copayments.

- **Well Woman Examinations**

  You do not need a referral to see a BlueLincs participating gynecologist for your annual "well woman" exam. This exam includes a pap smear, a pelvic exam and an occult blood lab once every twelve months. **Simply contact Member Services before you go to the doctor. Member Services will confirm that you have selected a participating gynecologist. You will also receive an authorization number that you must take to your scheduled appointment.** Any follow-up care required after your routine "well woman" exam (including mammography screening) must be coordinated by your PCP. If you need additional specialty care from a gynecologist, your PCP will refer you to a BlueLincs participating gynecologist within his or her Medical Group Network.

- **Well Man Examinations**

  You do not need a referral to see a BlueLincs participating urologist for your annual "well man" exam. This exam includes an office visit, a prostate exam and an occult blood lab once every twelve months**. Simply contact Member Services before you go to the doctor. Member Services will confirm that you have selected a participating urologist. You will also receive an authorization number that you must take to your scheduled appointment.** Any follow-up care required after your routine "well man" exam (including a PSA test) will be coordinated by your PCP. If you need additional specialty care from a urologist, your PCP will refer you to a BlueLincs participating urologist within his or her Medical Group Network.

- **Hospital Services**

  Hospital Services must be approved by your PCP and BlueLincs. You should verify with your PCP that Hospital Services have been approved through BlueLincs. When receiving Hospital Services, be sure to present your ID card and pay any required Copayments.

- **Emergency Care**

  BlueLincs defines Emergency Care as treatment for any injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

- serious jeopardy to the Member's health;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

Examples include, but are not necessarily limited to: major trauma, loss of consciousness, suspected heart attacks, severe abdominal or chest pains, fractures, uncontrolled bleeding, burns, attempted suicide or poisonings.

I**f you need Emergency Care, go to the nearest appropriate facility** and call your PCP within 48 hours of the incident. Your PCP's telephone number can be found on your BlueLincs ID card. All follow-up care required after an emergency must be provided or prearranged through your PCP.

- **Urgent Care – Within the State of Oklahoma**

  Urgent Care is defined as treatment for an unexpected illness or injury that is not an emergency, but which is severe or painful enough to require treatment within 24 hours. Examples include, but are not necessarily limited to: lacerations, high fever, vomiting and diarrhea, pulled muscles, or other similar illnesses or injuries.

  If you need Urgent Care, place a call to your PCP to explain the illness or injury. Your PCP may instruct you in a method of home care, ask you to come to the office or advise you to go to a minor emergency care center or emergency room. Use of the minor emergency care center or emergency room for Urgent Care that is not preauthorized by your PCP is not covered. All follow-up care must be provided or prearranged through your PCP.

- **Urgent Care – Outside the State of Oklahoma**

  As a BlueLincs Member, you have access to the BlueCard Program if you become ill while traveling. The BlueCard Program allows you to receive care from outside of the geographic area in which BlueLincs' network operates.

When you are away from home and you need to find information about a Physician or Hospital, you have access to a Provider finder 24 hours a day. The Provider finder is available by calling 1-800-810-BLUE (2583), or you may refer to the BlueCard Doctor and Hospital finder at www.bcbs.com. You may make an appointment with a Provider that is convenient to you.

Your care will be covered as if you had received it at home through BlueLincs. You will not have to complete a claim form or pay up front for your health services, except for those out-of-pocket expenses (noncovered services, Copayments and/or Deductibles) that you would pay anyway.

Always remember to carry your current BlueLincs ID card. It contains helpful information and important phone numbers for accessing health care when you are away from home.

Copayments and Deductibles

You, as a Member, have a responsibility to pay Copayments and/or Deductibles as outlined in your Schedule of Benefits. (Not all Group Health Plans require a Deductible to be paid by the Member. Refer to your Schedule of Benefits to determine if you must pay a Deductible annually.)

Copayment is defined as an amount you must pay in connection with the delivery of Covered Services.

Deductible is defined as a specified dollar amount of Covered Services that you must incur before BlueLincs will start to pay its share of the remaining Covered Services.

- Subscriber Only Coverage: When the Deductible specified in the Schedule of Benefits is reached, no additional Deductible will be required for Covered Services Incurred by you during the remainder of the Benefit Period.

- Dependent Coverage: When a family enrolled under Dependent coverage reaches the family Deductible specified in the Schedule of Benefits, no additional Deductible will be required for Covered Services Incurred by you or your Eligible Dependents under the same Dependent coverage during the remainder of the Benefit Period.

Copayments and Deductibles are applied to your health care costs as follows:

- The annual Deductible amount is applied once each Calendar Year for each Member.

- The Deductible does not apply toward the Out-of-Pocket Maximum.

- Payments for Prescription Drugs, supplemental services and noncovered services do not apply toward the Deductible.

- If the Group changes carriers during a Benefit Period, BlueLincs will apply expenses the Member Incurred during the Benefit Period for services covered under the prior contract to the Deductible of the Member's first Benefit Period under this Plan.

- If your coverage includes Dependents, then no more than three times the individual Deductible must be satisfied in each Benefit Period for all family members covered under your membership. No family member will contribute more than the individual Deductible amount.

- If the Copayment is based on a percentage, then the Deductible applies before the Copayment. If the Copayment is a dollar amount, then the Deductible applies after the Copayment.

If you have any questions regarding the application of Copayments and/or Deductibles as it relates to your Plan, please contact Member Services at 918-561-9933 in Tulsa or 405-841-9777 in Oklahoma City, or our toll free number 1-800-580-6202.

Out-of-Pocket Maximum

To make sure that your Copayments do not become a burden, there is a maximum amount of Copayments you are required to pay during a Benefit Period. This is called your Out-of-Pocket Maximum, and the specific dollar amount will be listed in your Schedule of Benefits. After you reach your Out-of-Pocket Maximum for a specific Benefit Period, you will not have to pay Copayments for Covered Services. If you have Family Coverage, only three family Members need to reach the Out-of-Pocket Maximum.

Copayments for the following do not apply to the Out-of-Pocket Maximum: Prescription Drugs, certain Inpatient mental health services, alcohol and substance abuse services, nonauthorized services, services provided by a nonparticipating Provider, Self-Referral Services, supplemental services, noncovered services and Deductibles.

It is important for you to keep track of your Copayment amounts during each Benefit Period. When you reach your Out-of-Pocket Maximum, send BlueLincs your request for a refund with receipts and statements within 120 days following the end of the Benefit Period. If you have overpaid, BlueLincs will reimburse you within 60 days after we receive your request.

BlueLincs is not responsible for your failure to comply with this notification provision, or liable for payment of any excess Copayments you have made during a Benefit Period after the time specified above.

Designating an Authorized Representative

BlueLincs has established procedures for you to designate an individual to act on your behalf with respect to a benefit claim or an appeal of an adverse benefit determination. Contact a Member Services Representative for help if you wish to designate an authorized representative. In the case of a Pre-authorization/Precertification Request Involving Urgent Care, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.

Preauthorization/Precertification

Preauthorization/Precertification is the process of requiring Participating Providers or Medical Group Participating Providers to obtain authorization from a Member's Primary Care Physician and/or BlueLincs and/or the Medical Group's Managed Care Committee prior to scheduling all non-primary care Medical Services (excluding Emergency Care). Failure to follow this process will result in denial of benefits. The Preauthorization/Precertification process may be handled by BlueLincs, your PCP and/or your Medical Group. In any event, the process for obtaining Preauthorization/Precertification is as follows:

Preauthorization/Precertification Requests Involving Non-Urgent Care

Except in the case of a Request Involving Urgent Care (see below), you will be provided with a written response to your request no later than 15 days following the date we receive your request. This period may be extended one time for up to 15 additional days, if it is determined that additional time is necessary due to the nature or complexity of the request.

If additional time is necessary, you will be given written notification, prior to the expiration of the original 15-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the determination will be given.

If an extension of time is necessary due to the need for additional information, you will be notified of the specific information needed, and you will have 45 days from receipt of the notice to provide the additional information. If information or documents are needed from a Participating Provider, BlueLincs will request the information from the Provider. BlueLincs will provide a written response to your request for Preauthorization/Precertification within 15 days following receipt of the additional information.

The procedure for appealing an adverse Preauthorization/Precertification determination is set forth in the section entitled "Member Complaints and Appeals."

Preauthorization/Precertification Requests Involving Urgent Care

A "Request Involving Urgent Care" is any request for medical care or treatment for an unexpected illness or injury that is not an emergency, but which is severe or painful enough to require treatment within 24 hours. Examples include, but are not necessarily limited to: lacerations, high fever, severe vomiting and diarrhea, pulled muscles or other similar illnesses or injuries.

A request will be deemed to involve Urgent Care if, in the opinion of your Physician, the application of the time periods for making non-urgent determinations would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

In case of a Request Involving Urgent Care, a response will be given to you no later than 72 hours after receipt of the request, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such failure, you will be notified no later than 24 hours after receipt of your request of the specific information necessary to complete your Preauthorization/Precertification request. You will be given a minimum of 48 hours to provide the specified information. You will be notified of the response to your request no later than 48 hours after the earlier of:

- the receipt of the specified information; or
- the end of the 48-hour period you were given to provide the specified information.

BlueLincs' response to your Request Involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

Preauthorization/Precertification Requests Involving Emergency Care

If you need Emergency Care, you should go to the nearest appropriate facility and call your PCP within 48 hours of the incident to arrange for follow-up care. Your PCP's telephone number can be found on your BlueLincs ID card. All follow-up care required after an emergency must be provided or prearranged through your PCP.

NOTE: Group Health Plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Special Benefit Provisions

Human Organ, Tissue and Bone Marrow Transplant Services

All transplants are subject to Precertification and must be performed in and by a Provider that meets the criteria established by BlueLincs for assessing and selecting Providers for transplants.

Precertification must be obtained at the time you are referred for a transplant consultation and/or evaluation. It is your responsibility to make sure Precertification is obtained. Failure to obtain Precertification will result in denial of benefits. BlueLincs has the sole and final authority for approving or declining requests for Precertification.

- **Definitions**

  In addition to the definitions listed under the Definitions section of this Member Handbook, the following definitions shall apply and/or have special meaning for the purpose of this section:

  – **Bone Marrow Transplant**

    A medical and/or surgical procedure comprised of several steps or stages including:

    - the harvest of stem cells or progenitor cells, whether from the bone marrow or from the blood, from a third-party donor (allogeneic transplant) or from the patient (autologous transplant);
    - processing and/or storage of the stem cells or progenitor cells after harvesting;
    - the administration of High-Dose Chemotherapy and/or High-Dose Radiation Therapy, when this step is prescribed by the treating Physician;
    - the infusion of the harvested stem cells or progenitor cells; and
    - hospitalization, observation and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts.

The above definition of autologous Bone Marrow Transplant specifically includes transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvested directly from the bone marrow, a procedure commonly known as peripheral stem cell or progenitor cell transplant or rescue procedure. This definition further specifically includes all component parts of the procedure including, without limitation, the High-Dose Chemotherapy and/or High-Dose Radiation Therapy.

- **High-Dose Chemotherapy**

  A form of Chemotherapy wherein the dose exceeds standard doses of Chemotherapy to the extent that virtually all patients who receive High-Dose Chemotherapy sustain destruction of the bone marrow to the point that bone marrow or peripheral stem cells or progenitor cells must be implanted or infused to keep the patient alive.

- **High-Dose Radiation Therapy**

  A form of Radiation Therapy wherein the dose exceeds standard doses of Radiation Therapy resulting in destruction of the bone marrow to the point that bone marrow or peripheral stem cells or progenitor cells must be implanted or infused to keep the patient alive.

- **Precertification**

  Certification from BlueLincs that, based on the information submitted by your attending Physician, benefits will be provided under the Agreement. Precertification is subject to all conditions, exclusions and limitations of the Agreement. Precertification does not guarantee that all care and services you receive are eligible for benefits under the Agreement.

- **Procurement Services**

The services provided to search for and match the human organ, tissue, bone marrow, peripheral stem cells, or progenitor cells donated to the transplant recipient, surgically remove the organ, tissue, bone marrow, peripheral stem cells, or progenitor cells from the donor and transport the organ, tissue, bone marrow, peripheral stem cells, or progenitor cells to the location of the recipient within 24 hours after the match is made.

- **Transplant Services**

  - **Organ and Tissue Transplant Procedures**

    Subject to the exclusions, conditions and limitations of the Agreement, benefits will be provided for Covered Services rendered by a Hospital, Physician or other Provider for the human organ and tissue transplant procedures set forth below.

    - Musculoskeletal transplants;
    - Parathyroid transplants;
    - Cornea transplants;
    - Heart-valve transplants; and
    - Kidney transplants.

  - **Other Major Organ Transplant Procedures**

    Subject to the exclusions, conditions and limitations of the Agreement, benefits will be provided for Covered Services rendered by a Hospital, Physician or other Provider for the human organ and tissue transplant procedures set forth below.

    - Heart Transplants

      Benefits will be provided for a heart transplant, provided you:

      - have terminal heart disease with a life expectancy of 18 months or less;
      - have normal liver and kidney function;
      - have no concurrent malignancy, HIV (human immunodeficiency virus) infection or AIDS (acquired immunodeficiency syndrome); and
      - are psychologically stable and have a supportive social environment.

    - Single Lung, Double Lung and Heart/Lung Transplants

      Benefits will be provided for a single lung, double lung or heart/lung transplant, provided you:

      - have end-stage cardiopulmonary or pulmonary disease with a life expectancy of 18 months or less;
      - have no concurrent malignancy, HIV infection or AIDS;
      - have normal liver and kidney function; and

- are psychologically stable and have a supportive social environment.

- Liver Transplants

  Benefits will be provided for a liver transplant, provided you:

  - have end-stage liver disease with a life expectancy of 18 months or less due to any of the following conditions:

    - extrahepatic biliary atresia;
    - primary biliary cirrhosis;
    - primary sclerosing cholangitis;
    - antigen-negative hepatitis B, antigen-negative or antigen-positive hepatitis C;
    - hepatic vein thrombosis (Budd-Chiari syndrome);
    - certain inborn errors of metabolism (such as Alpha-1-antitrypsin deficiency, Wilson's disease and primary hemochromatosis);
    - primary hepatocellular carcinoma; or
    - primary autoimmune hepatitis;

  - have normal kidney function;
  - have no concurrent extrahepatic malignancy (including extrahepatic extension or primary hepatocellular carcinoma), HIV infection or AIDS; and
  - are psychologically stable and have a supportive social environment.

  No benefits will be provided for a Member with end-stage liver disease as a result of viral hepatitis where the Member remains antigen positive (except for hepatitis C), or whose primary cause of liver damage is secondary to alcohol abuse, unless it can be demonstrated that the Member has abstained from alcohol for a period of no less than 12 months.

- Intestinal Transplants

  Benefits will be provided for a small bowel transplant using a cadaveric intestine for adult and pediatric Members with short-bowel syndrome who have established long-term dependency on total parenteral nutrition and who have developed severe complications due to parenteral nutrition, provided you:

  - have no concurrent malignancy, HIV infection or AIDS; and

- are psychologically stable and have a supportive social environment.

- Small Bowel/Liver or Multivisceral (Abdominal) Transplants

  Benefits will be provided for a small bowel/liver transplant or multivisceral transplant for adult and pediatric Members with short bowel syndrome who have been managed with long-term parenteral nutrition and who have developed evidence of impending end-stage liver failure, provided you:

  - have no concurrent malignancy, HIV infection or AIDS; and
  - are psychologically stable and have a supportive social environment.

- Pancreas Transplants

  - Benefits will be provided for a combined pancreas/kidney transplant for diabetic Members with uremia, provided the Member has no concurrent malignancy, HIV infection or AIDS, and is psychologically stable and has a supportive social environment.

  - Benefits will be provided for a pancreas transplant after a prior kidney transplant for Members with insulin dependent diabetes mellitus, provided the Member has no concurrent malignancy, HIV infection or AIDS, and is psychologically stable and has a supportive social environment.

  - Benefits will be provided for a pancreas transplant alone for Members with severely disabling and potentially life-threatening complications due to hypoglycemia unawareness and labile diabetes that persists in spite of optimal medical management, provided the Member has no concurrent malignancy, HIV infection or AIDS, and is psychologically stable and has a supportive social environment.

- Islet Cell Transplants

  Benefits will be provided for an autologous islet cell transplant for Members undergoing total or near total pancreatectomy for intractable pain due to chronic pancreatitis.

- **Bone Marrow Transplants**

  Not all autologous or allogeneic bone marrow transplants or stem cell or progenitor cell support procedures, whether performed as independent procedures or in combination with other therapies, e.g., High-Dose Chemotherapy and/or High-Dose Radiation Therapy, are covered. Benefits for Bone Marrow Transplants are not available for treatment of all conditions, or at all stages of a condition, even if the Provider may recommend such treatment.

  Subject to the exclusions, conditions and limitations of the Agreement, benefits will be provided for Covered Services rendered by a Hospital, Physician or other Provider for Bone Marrow Transplants to treat a condition on BlueLincs' list of approved conditions and medical criteria for eligibility of benefits (the "Approved List").

  If coverage is requested for a Bone Marrow Transplant procedure to treat a condition other than those on the Approved List, the request will be individually reviewed. If it is determined by BlueLincs that the transplant is not Medically Necessary for you, is Experimental or Investigational, or is otherwise excluded from coverage, benefits will be denied.

  Medical research regarding the effectiveness of Bone Marrow Transplant procedures is ongoing. BlueLincs periodically reviews conditions to determine eligibility for benefits. You or your treating Provider may obtain the Approved List of conditions and medical criteria for eligibility for benefits upon request.

- **Exclusions and Limitations Applicable to Organ/Tissue/Bone Marrow Transplants**

  - In addition to the exclusions set forth elsewhere in the Agreement and Schedule of Benefits, no benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:

    - Adrenal to brain transplants.
    - Allogeneic islet cell transplants.
    - High-Dose Chemotherapy or High-Dose Radiation Therapy if the associated autologous or allogeneic bone marrow transplant, stem cell or progenitor cell treatment or rescue is not a Covered Service.
    - Autologous or allogeneic bone marrow transplant and/or stem cell or progenitor cell treatment or rescue with or without High-Dose Chemotherapy or High-Dose Radiation Therapy for breast cancer

patients with Stage I, II or III disease or with refractory Stage IV disease.

- Tandem transplants for autologous or allogeneic bone marrow or stem cell or progenitor cell treatment or rescue, with or without High-Dose Chemotherapy and/or High-Dose Radiation Therapy.
- Small bowel transplants using a living donor.
- Liver transplant for a Member with end-stage liver disease as a result of viral hepatitis where the Member remains antigen positive (except for hepatitis C), or whose primary cause of liver damage is secondary to alcohol abuse, unless it can be demonstrated that the Member has abstained from alcohol for a period of no less than 12 months.
- More than one organ of the same type, with the exception of a double-lung transplant done at one time. A heart-only, lung-only, or heart/lung transplant will be considered the same type organ.
- Any organ or tissue transplant or Bone Morrow Transplant from a non-human donor or for the use of non-human organs for extracorporeal support and/or maintenance.
- Any artificial device for transplantation/implantation.
- Any organ or tissue transplant or Bone Marrow Transplant procedure, which BlueLincs considers to be Experimental or Investigational in nature.
- Expenses related to the purchase, evaluation, Procurement Services or transplant procedure if the organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Member recipient.
- All services provided directly for or relative to any organ or tissue transplant, or Bone Marrow Transplant procedure, which is not specifically listed as a Covered Service in the Agreement.

– **Benefits for Procurement Services are limited to $15,000 for each transplant performed.**

– The transplant must meet the criteria established by BlueLincs for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures.

– The transplant must be performed in and by a Provider that meets the criteria established by BlueLincs for assessing and selecting Providers in the performance of organ or tissue transplants, or Bone Marrow Transplant procedures.

- **Donor Benefits**

  If a human organ, tissue or Bone Marrow Transplant is provided from a **living** donor to a human transplant recipient:

  - When both the recipient and the living donor are Members, each is entitled to the benefits of the Agreement.

  - When only the recipient is a Member, both the donor and the recipient are entitled to the benefits of the Agreement. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program. Benefits provided to the donor will be charged against the recipient's coverage under the Agreement.

  - When only the living donor is a Member, the donor is entitled to the benefits of the Agreement. The benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program available to the recipient. There are no Covered Services for the non-Member transplant recipient.

  - If any organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Member recipient, no Covered Services will be provided for the purchase price, evaluation, Procurement Services or procedure.

  - BlueLincs is not liable for transplant expenses incurred by donors, except as specifically provided.

- **Research-Urgent Bone Marrow Transplant Benefits Within National Institutes of Health Clinical Trials Only**

  Bone Marrow Transplants that are otherwise excluded by the Agreement as Experimental or Investigational are eligible for benefits if the Bone Marrow Transplant meets all of the following criteria:

  - It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is life threatening and that has a poor prognosis with the most effective conventional treatment. For purposes of this provision, a condition is considered life threatening if it has a substantial probability of causing premature death

and all other conventional treatments have failed, or are not medically appropriate;

- The Bone Marrow Transplant is available to the Member seeking it and will be provided within a clinical trial conducted or approved by the **National Institutes of Health**;

- The Bone Marrow Transplant is not available free or at a reduced rate; and

- The Bone Marrow Transplant is not excluded by another provision of the Agreement.

Mastectomy and Reconstructive Surgery

Subject to the exclusions, conditions and limitations of the Agreement (including the Copayment and/or Deductible provisions set forth in the Schedule of Benefits), the benefits for the treatment of breast cancer and other breast conditions shall include the following Covered Services.

- Inpatient Hospital Services for:

  - not less than 48 hours of Inpatient care following a mastectomy; and

  - not less than 24 hours of Inpatient care following a lymph node dissection for the treatment of breast cancer.

  However, coverage may be provided for a shorter length of Hospital Inpatient stay where the attending Physician, in consultation with the patient, determines that a shorter period of Hospital stay is appropriate.

- Coverage for reconstructive breast surgery performed as a result of a partial or total mastectomy. Covered Services shall consist of the following, when provided in a manner determined in consultation with the attending Physician and the patient:

  - reconstruction of the breast on which the mastectomy has been performed;

  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and

  - prostheses and physical complications at all stages of mastectomy, including lymphedemas.

Prescription Drug Benefits (If Applicable)

Prescription Drug Precertification Process

BlueLincs has designated certain drugs for which you must receive Precertification in order for benefits to be provided under the Prescription Drug benefits supplement.

- Precertification may be requested by you or your Physician before the drug is dispensed. When you present your prescription to a Participating Retail Pharmacy, the pharmacist will submit an electronic claim to BlueLincs to determine the appropriate benefits.
  - If the Precertification request is approved, the pharmacist will dispense the Prescription Order and collect the appropriate Copayment and/or Deductible amount from you.
  - If the Precertification request is denied, the pharmacist will receive an electronic message indicating that benefits are not available for the drug. You will be responsible for the full cost of the prescription.
- If Precertification of the drug has not been requested, Precertification may be coordinated through a Participating Retail Pharmacy at the time the Prescription Order is presented, in accordance with the following guidelines:
  - When the Participating Retail Pharmacy submits a claim electronically, the pharmacist will receive a message indicating that Precertification is required.
  - At your request, the pharmacist may dispense a three-day supply of the drug while BlueLincs completes the Precertification approval process. The pharmacist will collect the appropriate Copayment and/or Deductible amount from you at the time of purchase.
  - Once the three-day supply has been used, you may return to the Participating Retail Pharmacy to obtain the remainder of your Prescription Order. The Participating Retail Pharmacy will resubmit the claim electronically to determine whether the Precertification request has been approved or denied.

- If Precertification is approved for the drug, you may obtain the full Prescription Order from the Participating Retail Pharmacy, subject to any remaining Copayment and/or Deductible amount applicable to the balance of the drug quantity dispensed. (You will not be responsible for more than the Copayment and/or Deductible amount that would have been applicable if the entire Prescription Order had been dispensed when first presented to the Participating Retail Pharmacy.)

- If the Precertification request is neither approved nor denied within the 72-hour review period, you may consider the Precertification request has been approved. You may obtain the Prescription Order and submit a claim form to BlueLincs in order to obtain benefits for the Prescription Drugs. Prescription Drug claims are subject to the Properly Filed Claim provisions set forth in the Agreement. You will be notified of BlueLincs' decision to approve Precertification for the drug, or BlueLincs' determination that the prescribed drug does not meet its guidelines for Medical Necessity for the condition being treated.

- If you purchase a Prescription Drug from a nonparticipating pharmacy, or fail to present your ID card to a Participating Retail Pharmacy at the time of purchase, you will be responsible for paying the full cost of the Prescription Order. Benefits for Prescription Drugs are provided only when the Prescription Order is written by a Participating Physician and dispensed by a Participating Retail Pharmacy, except in emergency situations as determined by BlueLincs.

- If you present your Prescription Order to a Participating Retail Pharmacy and the electronic system is unavailable to determine the appropriate benefits, you should pay the Participating Retail Pharmacy for the Prescription Order. To receive reimbursement, you must submit a written request, along with the Participating Retail Pharmacy's itemized statement to:

BlueLincs HMO
Member Services Department
P. O. Box 21128
Tulsa, OK 74121-1128

Special Exclusions and Limitations for Prescription Drugs (If Applicable)

In addition to the exclusions set forth in the Prescription Drug Benefits Summary, the following special limitations shall apply to the benefits provided under this Prescription Drug Benefits supplement:

- Limitations on Benefits
  - Benefits will be provided for Prescription Drugs dispensed in the following quantities:
    - Up to a 30-day supply or 100 unit doses (whichever is less) for "non-maintenance" drugs; or
    - Up to a 90-day supply or 300 unit doses (whichever is less) for drugs designated by BlueLincs as "maintenance" legend Prescription Drugs.

    Prescription Drug benefits are not provided under the Agreement for charges for Prescription Drugs dispensed in excess of the above stated amounts.
  - Certain drugs, as designated by BlueLincs, are subject to Precertification approval prior to dispensing. BlueLincs may deny coverage for these drugs or specify that a limited quantity of the drugs may be dispensed.
  - Benefits will not be provided for a prescription refill until you have used 75% of the previous Prescription Order.
  - In order for a Prescription Drug obtained from a nonparticipating pharmacy to be covered, the following criteria must be met:
    - You are outside the Service Area and a Physician orders the Prescription Drug to treat a covered emergency condition (as determined by BlueLincs); or
    - Your Primary Care Physician orders immediate use of a Prescription Drug due to a Medical Necessity and no Participating Retail Pharmacy is open.

Benefits are limited to a three-day supply per Prescription Order in the case of Prescription Drugs for emergency conditions. **BlueLincs reserves the right to determine what constitutes an emergency or Medical Necessity.**

To receive reimbursement for emergency prescriptions, you must send BlueLincs the Participating Retail Pharmacy receipt showing payment, name of Prescription Drug, itemized cost and a written statement regarding the circumstances of the emergency.

- Termination of Benefits

  - When you cease to be eligible for coverage, as defined in the Agreement, Prescription Drug benefits will end on the effective date and time of your termination. In the event you purchase Prescription Drugs from a Participating Retail Pharmacy after the date of your termination, you shall be required to reimburse BlueLincs for any benefits it has paid and for which you were not eligible under the terms of the Agreement.

  - In the event BlueLincs receives notification of the Group's intent to terminate the Agreement, benefits for Prescription Drugs dispensed on or after that date will be limited to a 30-day supply for all Members covered under the Agreement.

Pharmacy Benefit Administration

BlueLincs contracts with a Pharmacy Benefit Manager (PBM) for certain pharmacy benefit management services, including drug rebate services. Among other contractual services, the PBM negotiates rebate arrangements with drug manufacturers and prepares and submits drug utilization reports to manufacturers. The PBM, in turn, makes drug rebate payments to BlueLincs, which vary based on a number of factors, including the PBM's arrangements with drug manufacturers and the total volume of claims for Prescription Drugs dispensed to BlueLincs Members as a group each period. BlueLincs applies these payments to general administrative expenses and Prescription Drug benefit administration expenses. Because drug rebates are calculated on a collective, retrospective basis and do not affect the amount charged by or paid to any dispensing Participating Retail Pharmacy, rebate payments received by BlueLincs do not affect the calculation of the amount of Copayment or Deductible by you.

Eligibility, Enrollment, Changes and Termination

This section explains:

- **How** and **when** you become eligible for benefits under the Plan;
- **Who** is considered an Eligible Dependent;
- **How** and **when** your coverage becomes effective;
- **How** to change types of coverage;
- **How** and **when** your coverage stops under the Agreement; and
- **What** rights you have when your coverage stops.

Who Is An Eligible Person

To be eligible to Enroll, an Eligible Person must reside or work in the BlueLincs Service Area.

Unless your Employer has specified otherwise to BlueLincs in writing, you are an Eligible Person if you are an Employee who works on a full-time basis with a normal workweek of 24 or more hours. If you work on a part-time, temporary or substitute basis, you are not considered an Eligible Person.

The date you become eligible is the date you satisfy the eligibility provisions specified by your Employer. Check with your Group Administrator for specific eligibility requirements that apply to your coverage.

Who Is An Eligible Dependent

If your Employer has provided us with the Dependent eligibility requirements under its Alternate Health Plan, those provisions will apply. Otherwise, an Eligible Dependent is defined as:

- your unmarried child, including a newborn child, adopted child, step-child or other child for whom you or your spouse is legally responsible, including a child on whose behalf a qualified medical child support order (QMCSO) has been issued.

  - Unmarried Dependent children under age 19 are eligible for coverage until December 31 coinciding with or following their 19th birthday.

  - Unmarried Dependent children who are enrolled as Full-Time Students, and who are financially dependent upon you or your spouse, are eligible for coverage until the end of the month coinciding with or following their 23rd birthday.

  - Unmarried Dependent children who are medically certified as Totally Disabled and dependent upon you or your spouse are eligible for coverage regardless of age.

  (NOTE**:** An alternative age may be mutually agreed upon by the Group and BlueLincs. Check with your Group Administrator for Dependent age limitations.)

  BlueLincs reserves the right to request verification of a Dependent child's age, dependency and/or status as a Full-Time Student or disabled Dependent child upon initial enrollment and from time to time thereafter as BlueLincs may require.

  BlueLincs also reserves the right to review a Physician's certificate of disability and/or request medical records and/or require a medical examination by an independent Physician to verify disability at your expense. BlueLincs will make the final determination as to whether the Dependent is Totally Disabled.

  If two Eligible Persons are married to each other, one may Enroll as a Subscriber and the other as a Dependent, or both may be enrolled as Subscribers. Their child or children may be covered as Dependents under either person's coverage, but not under both.

How to Enroll

To Enroll in the Plan, you must complete an application form provided by BlueLincs, including all information needed to determine eligibility.

IMPORTANT: In order to ensure that your application is processed and your coverage is effective at the earliest possible date, you must Enroll during your first period of eligibility (designated by your Group).

Initial Enrollment Period

Initial Group Enrollment

- If you are an Eligible Person on the Agreement Effective Date and your application for coverage is received by BlueLincs during the Group's Initial Enrollment Period, the Effective Date for you and your Eligible Dependents (if applicable) is the Agreement Effective Date.

- Initial Enrollment After the Agreement Effective Date

- If you become an Eligible Person after the Agreement Effective Date and your application is received by BlueLincs within 31 days of being first eligible, the Effective Date for you and your Eligible Dependents (if applicable) will be assigned by BlueLincs, according to the provisions of the Agreement in effect for your Group.

- Initial Enrollment of New Dependents

  You can apply to add Dependents to your coverage if we receive your application within 31 days after you acquire an Eligible Dependent (see special rules below for newborn and adopted children). The Effective Date for the Eligible Dependent will be the date the Dependent was acquired.

  – Newborn Children

    If you have a newborn child while covered under this Plan, the following rules apply:

    - If your coverage does not currently include Dependent children, you may add coverage for a newborn effective on the date of birth. However, your application to add coverage for the Dependent must be received by BlueLincs within 31 days of the child's birth, and you must make the required contribution for such coverage from the date of birth.

    - If your coverage already includes Dependent children, please contact Member Services within 31 days of the child's birth. The Effective Date for the newborn will be the child's birth date.

- If you choose not to enroll your newborn child, coverage for the child will be included under the mother's maternity benefits (provided the mother is enrolled under this Plan) for 48 hours following a vaginal delivery, or 96 hours following a cesarean section. There will be no additional coverage for the newborn child.

IMPORTANT: To expedite the handling of your newborn's claims, please make sure that BlueLincs receives your child's application or written notification (including your child's name and birth date) within 31 days of the child's birth.

– Adopted Children

An adopted child or a child Placed for Adoption may be added to your coverage, provided the application is received by BlueLincs within 31 days of the date the child is placed in your custody. The Effective Date for the child will be the date you assumed the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child. A copy of the court order or adoption placement papers must be submitted to BlueLincs with the application.

Qualified Court Orders for Medical Coverage for Dependent Children

BlueLincs will honor certain qualified medical child support orders (QMCSO). To be qualified, a court of competent jurisdiction must enter an order for child support requiring coverage under the Plan on behalf of your children. An order or notice issued through a state administrative process that has the force of law may also provide for coverage and be a QMCSO.

The order must include specific information such as:

- your name and address;
- the name and address of any child covered by the order;
- a reasonable description of the type of coverage to be provided to the child or the manner the coverage is to be determined;
- the period to which the order applies; and
- each Group Health Plan to which the order applies.

To be a qualified order, the order cannot require BlueLincs to provide any type or form of benefits or any option not otherwise provided by the Plan, except as otherwise required by law. You will be responsible for paying all applicable premium contributions, and any Copayment and/or Deductible or other cost sharing provisions that apply to your or your Dependent's coverage.

BlueLincs has to follow certain procedures with respect to qualified medical child support orders. If such an order is issued concerning your child, you should contact a Member Services Representative concerning these procedures. Call 918-560-9933 in Tulsa or 405-841-9777 in Oklahoma, or our toll free number 1-800-580-6202.

Special Enrollment Periods

Special Enrollment Periods are provided during which individuals **who previously declined coverage** are allowed to Enroll (without having to wait until the Group's next regular Open Enrollment Period). A Special Enrollment Period can occur if a person with other health coverage loses that coverage, or if a person becomes a Dependent through marriage, birth, adoption or Placement for Adoption. A person who Enrolls during a Special Enrollment Period is not treated as a Late Enrollee.

- Special Enrollment for Loss of Other Coverage

  The Special Enrollment Period for loss of other coverage is available to you and your Dependents who meet the following requirements:

  - You and your Dependent must otherwise be eligible for coverage under the terms of the Agreement.

  - When the coverage was previously declined, you or your Dependent must have been covered under another Group Health Plan or must have had other health insurance coverage.

  - When you declined enrollment for yourself or your Dependent, you stated in writing that coverage under another Group Health Plan or other health insurance coverage was the reason for declining enrollment. This paragraph applies only if:

    - you were required by BlueLincs to provide such a statement when you declined enrollment; and

- you were provided with notice of the requirement to provide the statement in this paragraph (and the consequences of your failure to provide the statement) at the time you declined enrollment.

– When you declined enrollment for you or your Dependent under the Agreement:

  - you or your Dependent had COBRA Continuation Coverage under another plan and COBRA Continuation Coverage under that other plan has since been exhausted; or

  - if the other coverage that applied to you or your Dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contribution toward the other coverage has been terminated.

  For purposes of the above provision, "exhaustion of COBRA Continuation Coverage" means that your COBRA Continuation Coverage has ceased for any reason other than failure to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with the Plan). "Loss of eligibility for coverage" includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure of you or your Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or any intentional misrepresentation of a material fact in connection with the Plan).

  Your application for special enrollment must be received by BlueLincs within 31 days following the loss of other coverage. Coverage under special enrollment must be effective no later than the first day of the month after BlueLincs receives your application for enrollment for yourself or on behalf of your Dependent(s).

NOTE: Be sure to include a copy of the Certificate of Coverage and any other supporting documentation (i.e., divorce or court papers) verifying the loss of coverage.

- Special Enrollment for New Dependents

A Special Enrollment Period occurs if you have a new Dependent by birth, marriage, adoption or Placement for Adoption. **The application to Enroll must be received by BlueLincs within 31 days following the birth, marriage, adoption or Placement for Adoption.** To Enroll an adopted child, a copy of the court order or adoption papers must accompany the child's application. Special enrollment rules provide that:

- You may Enroll when you marry or have a new child (as a result of marriage, birth, adoption or Placement for Adoption).
- Your spouse can be enrolled separately at the time of marriage or when your child is born, adopted or Placed for Adoption.
- Your spouse can be enrolled together with you when you marry or when your child is born, adopted or Placed for Adoption.
- A child who becomes your Dependent as a result of marriage, birth, adoption or Placement for Adoption can be enrolled when he or she becomes a Dependent.
- Similarly, a child who becomes your Dependent as a result of marriage, birth, adoption or Placement for Adoption can be enrolled if you Enroll at the same time.
- Coverage with respect to a marriage is effective no later than the first day of the month after the date the application is received.
- Coverage with respect to a birth, adoption or Placement for Adoption is effective on the date of the birth, adoption or Placement for Adoption.

- Special Enrollment for Court-Ordered Dependent Coverage

An Eligible Dependent is not considered a Late Enrollee if the application to add the Dependent is received by BlueLincs within 31 days after issuance of a court order requiring coverage be provided for a spouse or minor or Dependent child under your coverage. The Effective Date will be determined by BlueLincs in accordance with the provisions of the court order.

Open Enrollment Period/Late Enrollee

If you do not Enroll for coverage for yourself or your Eligible Dependent(s) during the Initial Enrollment Period or during a Special Enrollment Period, you may apply for coverage at any time. However, coverage will be delayed until the Group's next Agreement Anniversary Date. In order to verify the coverage election, you and/or your Dependent(s) will be asked to "reapply" for coverage during the Group's Open Enrollment Period. An Open Enrollment Period will be held each year during the 31-day period immediately preceding the Group's Agreement Anniversary Date (renewal date) or during another period as agreed to between the Group and BlueLincs.

Delayed Effective Date

If you apply for coverage and are not Actively at Work on what would be your Effective Date, the Effective Date will be delayed until the date you are Actively at Work. This provision will not apply if you were:

- enrolled under the Employer's Group Health Plan in force immediately preceding the Agreement Effective Date; or

- covered under the Employer's Alternate Health Plan, except as may be specifically provided for in such Alternate Health Plan.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Termination of a Dependent's Coverage

You can change your coverage to delete Dependents. The change will be effective at the end of the coverage period for which your premiums have been paid, except that:

- in the case of divorce, the change will be effective the date the divorce is granted; and

- if a Dependent child marries, coverage for that Dependent will cease on the marriage date.

COBRA Continuation Coverage

THIS PROVISION MAY NOT APPLY TO YOUR GROUP'S COVERAGE. PLEASE CHECK WITH YOUR GROUP ADMINISTRATOR TO DETERMINE IF YOUR GROUP IS SUBJECT TO COBRA REGULATIONS.

- Eligibility for Continuation Coverage

  When a Qualifying Event occurs, eligibility under this Plan may continue for you and/or your Eligible Dependents (including your widow/widower, your divorced or legally separated spouse and your children) who were covered on the date of the Qualifying Event. A child who is born to you or Placed for Adoption with you during the period of COBRA Continuation Coverage is also eligible to elect COBRA Continuation Coverage.

  You or your Eligible Dependent is responsible for notifying the Employer of the occurrence of any of the following events:

  - Your divorce or legal separation;
  - Your Dependent child ceasing to be an Eligible Dependent under BlueLincs; or
  - The birth, adoption or Placement for Adoption of a child while you are covered under COBRA Continuation Coverage.

- Election of Continuation Coverage

  You or your Eligible Dependent must elect COBRA Continuation Coverage within 60 days after the later occurrence of:

  - The date the Qualifying Event would cause you or your Eligible Dependent to lose coverage; or
  - The date your Employer notifies you, or your Eligible Dependent, of your COBRA Continuation Coverage rights.

- COBRA Continuation Coverage Period

You and/or your Eligible Dependents are eligible for coverage to continue under your Group's coverage for a period not to exceed the following, provided the premiums are paid for the coverage as required:

- 18 months from the date of a Qualifying Event involving your termination of employment (other than for reason of gross misconduct) or reduction in working hours; or

- 36 months from the date of a Qualifying Event involving:

  - your death, divorce or legal separation, or your loss of coverage due to becoming entitled to Medicare benefits; or

  - the ineligibility of a Dependent child.

- Disability Extension

  COBRA Continuation Coverage may be extended from 18 months to 29 months for you or an Eligible Dependent who is determined by the Social Security Administration to have been disabled on the date of a Qualifying Event, or within the first 60 days of COBRA Continuation Coverage. This 11-month disability extension is also available to non-disabled family members who are entitled to COBRA Continuation Coverage. To request the 11-month disability extension, you or your Dependent must notify your Employer before the end of the initial 18-month COBRA Continuation Period, and no later than 60 days after the date the Social Security Administration's determination is received. In addition, you or your Eligible Dependent must notify your Employer within 30 days after the Social Security Administration makes a determination that you or your Eligible Dependent is no longer disabled.

- Multiple Qualifying Events

  In the event an Eligible Dependent experiences a second Qualifying Event after onset of COBRA Continuation Coverage resulting from your termination or reduction in work hours, the maximum period of coverage is 36 months from the date of the first Qualifying Event. This extension is available to the Eligible Dependent only.

Conversion Privilege After Termination of Group Coverage

If you stop being a Member under the Agreement or you change jobs and your new employer does not offer group health insurance, and if you continue to reside or work in the BlueLincs Service Area, you may apply for conversion coverage by following these procedures:

Contact the BlueLincs Enrollment Department at 918-560-2387 to request conversion information and an application form.

- Complete the application and **send it directly to BlueLincs within 31 days of the date your Group coverage ended**. Your coverage will become effective the day after your Group coverage terminates if the appropriate premium is paid and the procedures mentioned above are followed.

A conversion contract will not be available if your coverage is terminated due to:

- nonpayment of premium by your Employer;
- termination by BlueLincs;
- nonpayment of required Copayments and/or Deductibles;
- commission of fraud or misrepresentation; or
- termination of the Agreement.

If you move your residence outside and no longer work within the BlueLincs Service Area, you may convert to an individual hospital and surgical expense policy issued by an insurance carrier determined by BlueLincs, subject to the same conditions specified above for a BlueLincs individual conversion policy. To apply, contact the BlueLincs Enrollment Department within 31 days of the date your BlueLincs coverage ends. The individual conversion policy is renewable at the option of the insurance carrier.

When Coverage Under Your Plan Ends

When you are no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the coverage period for which premiums have been paid, except in the following cases:

If you stop being an Eligible Person because your employment ends, coverage for you and your Eligible Dependents, if any, will stop at the end of the coverage period for which your premiums have been paid, or the 31st day following the date your employment ends, whichever occurs first. (NOTE: An alternative termination date may be mutually agreed upon by the Group and BlueLincs. Check with your Group Administrator for specific termination provisions.)

- When a Member ceases to be an Eligible Dependent by reason of divorce, coverage for that Member will cease on the date the divorce is granted or on the date specified by the Member's spouse, whichever is earlier, unless superseded by a court order.

- When a Member ceases to be an Eligible Dependent by reason of death, coverage for that Member will cease on the date of death.

- When a Member ceases to be an Eligible Dependent child because he/she has married, coverage for that Member will cease on the marriage date.

- When a Member ceases to be an Eligible Dependent child because he/she has reached the age limit for Dependent children (unless medically certified as Totally Disabled), coverage for that Member will end as follows:

  - For a Dependent child who attains the age of 19, coverage will end on December 31st coinciding with or following the child's 19th birthday.

  - For a Dependent child who is a Full-Time Student, coverage will stop at the end of the month coinciding with or following the child's 23rd birthday, or when the child is no longer a Full-Time Student, whichever occurs first.

  (NOTE: An alternative age may be mutually agreed upon by the Group and BlueLincs. Check with your Group Administrator for Dependent age limitations.)

- Coverage of the Member shall terminate on the date the Member becomes covered under the Employer's Alternate Health Plan (if applicable).

- When a Subscriber moves out of the BlueLincs Service Area and does not work within the BlueLincs Service Area, coverage for the Subscriber and his/her Dependents, if any, shall terminate under the Agreement on the date of the change in permanent residence.

- If you fail to make the required Copayment, or to pay any Deductible as specified in your Schedule of Benefits, coverage for you and your Eligible Dependents will terminate 30 days after notice is given to you and the Group.

- Your coverage (including coverage of your Eligible Dependents) will terminate retroactive to your Effective Date if you or the Group commits fraud or material misrepresentation in applying for or obtaining coverage

under the Agreement. Your coverage will end immediately if you file a fraudulent claim.

- If BlueLincs, after reasonable efforts, is unable to establish and maintain a satisfactory Physician-patient relationship with you or your Eligible Dependents, coverage will end following a 30-day written notice to you, your Eligible Dependents and the Group.

- In the event you fail to cooperate fully with BlueLincs in its right of recovery, determination of workers' compensation coverage, or coordination of benefits efforts, coverage for you and your Eligible Dependents will end after a 30-day notice is sent to you or your Eligible Dependents and the Group.

- A Member's COBRA Continuation Coverage, when applicable, shall cease on the earliest of the following dates:

  - the date the coverage period ends following expiration of the 18-month, 29-month or 36-month Continuation Coverage period, whichever is applicable;

  - the first day of the month that begins more than 30 days after the date of the Social Security Administration's final determination that the Member is no longer disabled (when coverage has been extended from 18 months to 29 months due to disability);

  - the date on which the Group stops providing **any** Group Health Plan to **any** Employee;

  - the date on which coverage stops because of a Member's failure to pay to the Group any premiums required for the Continuation Coverage;

  - the date on which the Member first becomes **covered** under any other Group Health Plan which does not contain any exclusion or limitation with respect to a preexisting condition applicable to the Member (or the date the Member has satisfied the preexisting condition exclusion period under that plan); or

  - the date on which the Member becomes entitled to benefits under Medicare.

- If your premiums are not paid, your coverage will stop at the end of the coverage period for which your premiums have been paid.

- If applicable, payment made for coverage beyond the termination date specified above will be refunded to the Group.

- Termination of the Agreement automatically ends all of your coverage at the same time and date. It is the responsibility of your Group to tell you of such termination.

When You Turn Age 65

If you continue working full time, this Plan will continue to provide the same benefits that apply to Employees under age 65. Coverage for your spouse and Dependents will also continue.

If your group coverage ends and you are age 65 or older, contact BlueLincs for details regarding coverage options available to supplement your Medicare coverage.

NOTE: Some groups have special eligibility provisions regarding retired employees. Check with your Group Administrator for retiree eligibility provisions unique to your Group's coverage.

IMPORTANT: You are eligible for Medicare on the first day of the month you become age 65. You should apply for Medicare at least three months before your birthday.

Address Change

Please let BlueLincs know when you move or change your address. You can get a change of address form from your Employer or Group Benefits Administrator, and they will send the form to us.

If you are the Subscriber and move out of the BlueLincs Service Area, it is important that you notify your Employer or Group Benefits Administrator as you may no longer be eligible for BlueLincs coverage. You may be eligible for your Employer's Alternate Health Plan or you may call Member Services for other coverage options.

Certificates of Coverage

A Certificate of Coverage will be provided, without charge, for individuals who are or were covered under a Group Health Plan upon the occurrence of any of the following events:

- Qualified Beneficiaries Upon a Qualifying Event

- In the case of an individual who is a qualified beneficiary entitled to elect COBRA Continuation Coverage, an automatic Certificate of Coverage is required to be provided at the time the individual would lose coverage under the Plan in the absence of COBRA Continuation Coverage or alternative coverage elected instead of COBRA Continuation Coverage.

- Other Individuals When Coverage Ceases

- In the case of an individual who is not a qualified beneficiary entitled to elect COBRA Continuation Coverage, an automatic Certificate of Coverage is required to be provided at the time the individual ceases to be covered under the Plan.

- Qualified Beneficiaries When COBRA Ceases

- In the case of an individual who is a qualified beneficiary and has elected COBRA Continuation Coverage (or whose coverage has continued after the individual became entitled to elect COBRA Continuation Coverage), an automatic Certificate of Coverage will be provided at the time the individual's coverage under the Plan ceases.

- Any Individual Upon Request

- Requests for Certificates of Coverage are permitted to be made by, or on behalf of, an individual within 24 months after coverage ceases.

- The Certificate of Coverage gives detailed information about how long you had coverage under the plan. This information may be used to demonstrate "Creditable Coverage" to your new health plan or issuer of an individual health policy. Creditable Coverage may be used to reduce the preexisting condition exclusion period under the new coverage.

- BlueLincs has a toll-free telephone number (1-800-580-6202) to assist Members in obtaining Certificates of Coverage and preexisting condition "credit" under another Group Health Plan.

Benefits After Termination of the Agreement

If the Agreement terminates because BlueLincs ceases to operate, or because BlueLincs elects, for any reason **other than** breach of contract (including default of premium or failure to meet the enrollment requirements for minimum

percentage and number of Eligible Persons) to terminate the Agreement, any Member who is hospitalized for a sickness or injury or who is pregnant on the effective date of termination shall continue to receive benefits for Covered Services for such hospitalization or pregnancy, provided that:

- The continuing care for hospitalization shall be for the condition under treatment until the earlier of:
  - the Member's discharge from the Hospital or Skilled Nursing Facility; or
  - 30 days from the date of termination of the Agreement.
- In maternity cases under care at the effective date of termination, BlueLincs may either, at its option:
  - continue obstetrical care through confinement and discharge; or
  - convert the Member from Group to individual membership.

The above provisions shall not apply if the Member becomes covered under an Alternate Health Plan, or any other plan offered by, through or in connection with the Employer as an option in lieu of coverage under the Agreement.

BlueLincs shall have no liability for any benefits for Covered Services Incurred after termination of the Agreement, except as provided above.

Other Coverage and Right of Recoupment

Coordination of Benefits

When a Member or a Dependent has health coverage with more than one health plan, there will be times when the two health plans will need to coordinate benefit coverage to decide who is responsible for payment to Providers. This is called coordination of benefits (COB).

Please note that this section only applies if the Member or Dependent has health coverage under more than one plan.

Definitions

In addition to the definitions listed in the back of this Member Handbook, the following definitions apply to this COB provision:

- **"Other Agreement"** means any arrangement providing health care benefits or services through:
  - group, blanket or franchise insurance coverage;
  - Blue Cross, Blue Shield, Health Maintenance Organization and other prepayment coverage.
  - coverage under labor-management trusteed plans, union welfare plans, Employer organization plans, or employee benefit organization plans;
  - coverage toward the cost of which any Employer shall have contributed, or with respect to which any Employer shall have made payroll deductions; and
  - coverage under any tax supported or government program to the extent permitted by law.
- **"Covered Service"** additionally means a service or supply furnished by a Hospital, Physician or other Provider for which benefits are provided under at least one Other Agreement covering the person for whom the claim is made or service provided.

- **"Dependent"** additionally means a person who qualifies as a Dependent under an Other Agreement.

- **"Primary Plan"** means the other coverage that pays benefits or provides services first under the Order of Benefit Determination Rules below.

- **"Secondary Plan"** means any other coverage that is not a Primary Plan.

All benefits provided under the Agreement are subject to this COB provision.

It is the responsibility of each Member to advise BlueLincs of his or her participation in any Other Agreement. We will occasionally request information from you regarding duplicate health coverage. This information is also requested on the BlueLincs application. Please complete and return the requested information promptly to ensure timely processing of your claims.

BlueLincs follows the COB rules established by state law, including the rules for determining the order in which benefits are to be paid on behalf of Dependent children. Therefore, our Members **do not** have the option of choosing which plan they wish to have pay benefits first.

All Covered Services (except where Medicare is primary) must be preauthorized or precertified by your PCP and/or BlueLincs in accordance with the provisions of the Agreement and Schedule of Benefits.

Medicare

When Medicare is the primary payor, you may seek services from any Participating Medicare Provider.

Your Plan provides primary coverage for the following covered Medicare-eligible individuals:

- Active Employees and their spouses, **unless coverage is through an Employer with 20 Employees or less**;

- Members who are on renal dialysis for 30 months or less; and

- Members who are under 65 and who are eligible for Medicare by reason of disability.

For all other Medicare beneficiaries, Medicare is the primary carrier.

While primary medical coverage is being provided under this Plan, you may wish to enroll in Medicare, as expenses not reimbursed under this Plan may be reimbursed under Medicare. Be sure to apply for Medicare Part A (Hospital Insurance) and Part B (supplemental medical insurance) at least three months before your 65th birthday.

When Medicare provides primary coverage, this Plan will reduce benefits payable for Covered Services by any benefits payable for the same Covered Services under Medicare.

When BlueLincs pays its benefits **secondary** to Medicare, Members should always submit the Medicare "explanation of benefits" (EOB) form along with any statements of services rendered when filing claims for **secondary** benefits with BlueLincs.

The coverage of any Member who fails to cooperate with BlueLincs in this effort may be terminated under the provisions of the Agreement.

Order of Benefit Determination Rules

When BlueLincs is the **Primary Plan**, BlueLincs will determine the benefits payable without regard to any Other Agreement.

When BlueLincs is the **Secondary Plan**, the benefits BlueLincs pays for Covered Services may be reduced and will not exceed the balance of charges remaining after the benefits of Other Agreements are applied to Covered Services.

Always submit claims to the Primary Plan first. When filing a claim for secondary benefits with BlueLincs, be sure to send a copy of your EOB form from the **Primary Plan**, along with itemized statements of services rendered for which the claim is made. **Your claim cannot be processed without the EOB and itemized statements.**

In coordinating benefits, the following rules determine the order of benefits:

- When a person who received care is covered as an Employee under one plan, and as a Dependent under another, then the Employee coverage pays first.

- When a Dependent child is covered under two plans, the plan covering the child as a Dependent of the parent whose birthday falls earliest in the Calendar Year pays first. (If one plan does not follow the "birthday rule" provision, then the rule followed by that plan is used to determine

the order of benefits.) However, when the Dependent child's parents are separated or divorced, the following rules apply:

- If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.

- When a divorced parent with custody has remarried, the coverage of the parent with custody pays first and the stepparent's coverage pays second before the coverage of the parent who does not have custody.

- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

When none of the above circumstances applies, the coverage the person has had for the longest time pays first. The only exception is a plan that covers an individual as a laid-off or retired Employee or as a Dependent of such person pays after a plan which covers that individual as other than a laid-off or retired Employee or Dependent of such person.

In order to make this coordination of benefits provision work properly:

- Upon request, the Member is required to furnish BlueLincs with complete information concerning all Other Agreements that cover the person for whom the claim is made. If such information is not furnished after a reasonable time, BlueLincs shall:

  - assume the Other Agreement is required to determine its benefits first;

  - assume the benefits of the Other Agreement are identical to the benefits of this coverage.

  Once BlueLincs receives the necessary information to determine your benefits under the Other Agreement and to establish the order of benefit determination under the rules listed above, prior payments under this coverage will be adjusted accordingly (if the above rules require it).

- If the other plan reduces your benefits because of payments you received under this coverage and the above rules do not allow such reduction, then BlueLincs will advance the remainder of your full benefits under this coverage as if your benefits had been determined in absence of an Other Agreement. However, BlueLincs shall be subrogated to all of your rights under the Other Agreement. You must furnish all information reasonably required by BlueLincs in such event, and you must cooperate and assist BlueLincs in recovery of such sums from the other plan.

- If the other carrier later provides benefits to you for which BlueLincs has made payments or advances under this COB provision, you must hold all such payments in trust for BlueLincs and must pay such amount to BlueLincs upon receipt.

- If payments that should have been made by BlueLincs under this Plan have been made under any other plans, BlueLincs will make the appropriate primary payments to the Provider. It will be the responsibility of the other plan to request reimbursement from the Provider for any overpayment.

- If BlueLincs has paid benefits that result in payment in excess of the amount necessary to make this provision work properly, BlueLincs has the right to recover such excess payment from any person, any insurance company or another organization to or for, or with respect to whom such payments were made. You agree to do whatever is necessary to secure BlueLincs' right to recover the excess payment. This right of recovery is limited to twenty-four (24) months after the payment is made, unless:

  - the payment was made because of fraud committed by you or your Provider; or

  - you or your Provider has otherwise agreed to make a refund to BlueLincs for overpayment of the claim.

Right of Recoupment

- You agree to reimburse BlueLincs for benefits it has paid and for which you were not eligible under the terms of the Agreement. This payment is due and payable immediately upon notification by BlueLincs. Also, BlueLincs has the sole right to determine that any overpayments, wrong payments or any excess payments made under the Agreement are an indebtedness which may be recovered by BlueLincs by deducting it from any future benefits under the Agreement, or under any other coverage provided by BlueLincs. BlueLincs' acceptance of premiums or payment of benefits under the Agreement does not waive its rights to enforce these provisions in the future.

- To the extent BlueLincs provides or pays benefits for Covered Services for any injury, illness or condition which occurs through the omission or commission of any act by another person, you agree that BlueLincs shall have a first lien on any settlement proceeds, and you shall reimburse and pay BlueLincs, on a first-priority basis, from any money recovered by suit, settlement, judgment or otherwise from any third party or his or her insurer

or from any carrier providing uninsured/underinsured motorist coverage. You shall reimburse BlueLincs on a first-priority basis regardless of whether a lawsuit is actually filed or not and, if settled, regardless of how the settlement is structured or which items of damages are included in the settlement, and regardless of whether or not you are made whole or are fully compensated for any injuries.

- You are required to hold in trust for BlueLincs any money (up to the amount of benefits paid by BlueLincs) recovered as described above. You are required to cooperate and furnish information and assistance which BlueLincs may require to obtain this reimbursement, including signing legal documents.

- Your failure to comply with the above provisions may result in termination of your coverage and/or legal action to enforce collection.

Workers' Compensation

BlueLincs will not exclude coverage for any injury or illness occurring in the course of employment for which whole or partial compensation or benefits are or might be available under the laws of any governmental unit, any policy of workers' compensation insurance, or according to any recognized legal remedy arising from an employer-employee relationship.

- However, BlueLincs and the Member agree that the Member will:

  pursue his or her rights under the workers' compensation laws;

  - take no action prejudicing the rights and interests of BlueLincs; and

  - cooperate and furnish such information and assistance BlueLincs requires to facilitate enforcement of its rights.

- The Member and BlueLincs further agree that BlueLincs may terminate the Member should the Member fail to reasonably cooperate and furnish such information and assistance BlueLincs requires to facilitate enforcement of its rights.

- If the Member receives any money in settlement of the employer's liability, regardless of how the settlement is structured, or which items of damages are included, the Member agrees to hold in trust said money for the benefit of BlueLincs and to repay BlueLincs any money recovered from the employer or insurance carrier to the extent that BlueLincs had paid any benefits or would be obligated to pay any benefits.

General Provisions

Cost Sharing Features of Your Coverage

As a participant in this Plan, you have the responsibility for sharing in a portion of your health care costs. You are responsible for the applicable Copayment and/or Deductible provisions of your coverage, as well as any charges for which benefits are not provided. You may also be responsible for a portion of your health care premiums, depending upon the terms of your Plan. Check with your Group Administrator for specific premium amounts applicable to the coverage you have selected for you and your family.

Limitation of Actions

No legal action may be taken to recover benefits within 60 days after Covered Services are rendered for which benefits are payable, and no such action may be taken later than three years after the provision of Covered Services.

Assignment of Benefits

All rights of Members to receive benefits for Covered Services are personal to the Member and may not be assigned to anyone else.

Determination of Benefits Eligibility

BlueLincs, as claims administrator, is hereby granted discretionary authority to interpret the terms and conditions of the Agreement and to determine its benefits.

BlueLincs may conduct a utilization review of the care and services provided to you to determine the Medical Necessity and benefit eligibility of the services rendered. The fact that a Physician may recommend or approve a service, prescription or supply does not, of itself, make it Medically Necessary or make the charge a Covered Service, even though it is not specifically listed as an exclusion. However, BlueLincs will not seek reimbursement from a Member for the cost of any benefit provided for Covered Services under the Agreement found to have been not Medically Necessary, provided that:

- the proper referral provisions of the Agreement were complied with; and

- the Member was not notified prior to the performance of the care and services that such care and services would not be Medically Necessary.

Utilization management decision-making is based only on appropriateness of care and service. The managed care organization does not compensate practitioners or other individuals conducting utilization review for denials of coverage or service. Financial incentives for utilization management decision-makers do not encourage denials of coverage or service.

BlueCard Program

As a BlueLincs Member, you have access to the BlueCard Program **if you require Emergency Care or Urgent Care while traveling outside the BlueLincs Service Area**. Follow-up care following an emergency is also available through the BlueCard Program, provided the services are preauthorized by BlueLincs.

Under BlueCard, when you obtain health care services outside the state of Oklahoma, the amount you pay, if not covered by a flat dollar Copayment, for Covered Services is calculated on the **lower** of:

- the actual billed charges for your Covered Services; or

- the negotiated price that the onsite Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted in the above paragraph or require a surcharge, BlueLincs would then calculate your liability

for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTE: BlueLincs may postpone or waive application of your Copayment and/or Deductible whenever it is necessary in order to obtain Provider discounts for Covered Services you receive outside the state of Oklahoma.

Inability to Provide Benefits

If BlueLincs becomes unable to provide benefits under this Plan due to events that are not reasonably within BlueLincs' control, such as complete or partial destruction of facilities, war, public disaster or emergency or general epidemic, BlueLincs will first attempt to provide services in non-BlueLincs facilities in the BlueLincs Service Area. If BlueLincs becomes unable to provide benefits under this Plan, BlueLincs may, upon approval of the Oklahoma Insurance Department or other required agency, terminate the Agreement after 60 days' general notice of such condition to Members. During this period, BlueLincs will be liable for payment, up to 30 days, of all Covered Services under this Plan for any Member who is hospitalized for reason of Medical Necessity until the Member is discharged from the Hospital.

Agency Relationships

The Group is your agent, not our agent.

Providers are not employees, agents or other legal representatives of BlueLincs.

BlueLincs/Association Relationship

Each Member hereby expressly acknowledges its understanding that the Agreement constitutes a contract solely between the Group and BlueLincs (a wholly owned subsidiary of Blue Cross and Blue Shield of Oklahoma), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BlueLincs to use the Blue Cross and Blue Shield Service Marks in the state of Oklahoma, and that BlueLincs is not contracting as the agent of the Association. It is further understood that the Group, on behalf of itself and each of its Members, has not entered into the Agreement based upon representations by any person other than BlueLincs and that no person, entity or organization other than BlueLincs shall be held accountable or liable to the Group or its Members for any of BlueLincs' obligations to the Group or Members created under the Agreement. This paragraph shall not create any additional obligations whatsoever on the part of

BlueLincs other than those obligations created under other provisions of the Agreement.

Quality Improvement

BlueLincs has a Quality Improvement Program in place to ensure continuous improvements in the quality of clinical care and the quality of service offered to its Members. BlueLincs annually makes information about the Quality Improvement Program and a report on BlueLincs' progress available. You may request this information by contacting Member Services.

Medical Technology Evaluation

BlueLincs evaluates new medical technology for possible inclusion as a covered benefit through its review of published medical research literature, comprehensive analyses of the technology's safety, efficacy and comparability to alternative technologies. The evaluation process does not require BlueLincs to change or amend the benefits, exclusions or limitations of coverage under the Member Handbook, Schedule of Benefits or Agreement.

Methods of Payment and Claim Filing

For Care Authorized by Your PCP

BlueLincs Members receive prepaid services from the first day of coverage with only minimal Copayments and/or Deductibles required for certain specified Covered Services. Therefore, in general, you will have no responsibility for filing of claims. Network Providers are paid directly by BlueLincs, except for your Copayment and/or Deductible and expenses for noncovered services.

For Covered Emergency Care or Urgent Care Services

In most cases, BlueLincs will reimburse the Hospital or Physician for the covered Emergency Care or Urgent Care services you have received. However, it may be necessary for you to file a claim with BlueLincs in order for these Providers to receive payment. A complete written statement of services rendered should be submitted with the Provider's bill. Please make sure that you receive such a statement from the Physician or Hospital. If a claims payment is made directly to you, **you** are responsible for paying the Provider of services.

In some instances, payment may be required at the time of service. If this occurs, please submit an itemized bill to BlueLincs for reimbursement.

If You Receive a Bill

You may receive bills while you are a Member of BlueLincs. If you receive a bill in error, for authorized Covered Services, or if you must file a claim yourself (for covered Emergency Care or Urgent Care services), send it to:

BlueLincs HMO
Member Services Department
P. O. Box 21128
Tulsa, OK 74121-1128

Or you can call 918-561-9933 in Tulsa, 405-841-9777 in Oklahoma City, or 1-800-580-6202.

Please make copies of the itemized bills for your file before you mail them to BlueLincs.

Timely Filing of Claims

Your Properly Filed Claim must be furnished to BlueLincs within 90 days after the end of the Benefit Period for which the claim is made. Failure to provide a Properly Filed Claim to BlueLincs within 90 days will not reduce any benefit if you show that the claim was given as soon as reasonably possible.

Benefit Determinations for Properly Filed Claims

Once BlueLincs receives a Properly Filed Claim from you or your Provider, a benefit determination will be made within 30 days. This period may be extended one time for up to 15 additional days if BlueLincs determines that additional time is necessary due to matters beyond our control.

If we determine that additional time is necessary, you will be notified, in writing, prior to the expiration of the original 30-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which BlueLincs expects to make the determination.

Upon receipt of your claim, if BlueLincs determines that additional information is necessary in order for your claim to be a Properly Filed Claim, we will provide written notice to you, prior to the expiration of the initial 30-day period, of the specific information needed. You will have 45 days from receipt of the notice to provide the additional information. BlueLincs will notify you of its benefit determination within 15 days following receipt of the additional information.

In some instances, your Medical Group may be receiving the claim and making the benefit determinations on behalf of BlueLincs.

The procedure for appealing an adverse benefit determination, whether made by BlueLincs or your Medical Group, is set forth in the section entitled "Member Complaints and Appeals."

Member Complaints and Appeals

BlueLincs has established the following process to review Member dissatisfactions, complaints and/or appeals. If you have designated an authorized representative, that person may act on your behalf in the appeal process.

If you have a question or complaint, an initial attempt should be made to resolve the problem by directly communicating with a BlueLincs Member Services Representative. In most cases, a Member Services Representative will be able to provide you with a satisfactory solution to your problem. However, if a resolution cannot be reached in an informal exchange, you may request an administrative review of the problem through our appeal process described below.

You may request to review information used to make any adverse determination. Copies will be provided free of charge.

Level I – Appeal

- **How and When to File an Appeal**

  If you are not satisfied with the initial attempt to resolve your problem, or if you wish to request a review of a benefit determination or Preauthorization/Precertification decision, you must request an appeal within 180 days from the date you received notice of the adverse benefit determination or Preauthorization/Precertification notice.

  – **How to File an Appeal Involving a Non-Urgent Request or Claim**

    In the case of an appeal involving a non-urgent request or claim, you must submit your request in writing to the following address:

    Member Appeal Coordinator – Member Services Department
    BlueLincs HMO
    P. O. Box 21128
    Tulsa, OK 74121-1128

The written request should include your name, your BlueLincs identification number, the nature of the complaint, the facts upon which the complaint is based, **and the resolution you are seeking**. Necessary facts are: dates and places of services, names of Providers of service, place of hospitalization and

services or procedures received (if applicable). You should include any documentation, including medical records, that you want to become a part of the review file. BlueLincs may request further information if necessary.

Within seven working days following BlueLincs' receipt of a Level I request, you will receive written notification outlining your rights and the time frames for determination.

– **How to File an Appeal of a Preauthorization/Precertification Request Involving Urgent Care**

If you wish to appeal a Request Involving Urgent Care, you may appeal by contacting Member Services at 1-800-580-6202.

- **The Appeal Process**

– **Appeal Involving a Non-Urgent Request or Claim**

BlueLincs' Benefits Administration management will review your appeal, unless it involves medical judgment. Appeals that require medical judgment are reviewed by the BlueLincs Medical Director. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational or not Medically Necessary or appropriate, BlueLincs may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

In the case of an appeal involving a non-urgent Preauthorization/ Precertification request, BlueLincs will provide a written response to you no later than 30 days following the date we receive your appeal.

In the case of an appeal involving a claim other than a Preauthorization/ Precertification request, BlueLincs will provide a written response to you no later than 60 days following the date we receive your appeal.

– **Appeal of a Request Involving Urgent Care**

A "Request Involving Urgent Care" will be forwarded to the BlueLincs Medical Director. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particu-

lar treatment, drug or other item is Experimental, Investigational or not Medically Necessary or appropriate, BlueLincs may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

BlueLincs will respond to you no later than 72 hours after receipt of your appeal request.

BlueLincs' response to your Request Involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

Level II – Voluntary Reconsideration Process

After exhaustion of the appeals process outlined above, you may elect to submit your benefit dispute to BlueLincs for reconsideration. We will provide you with information necessary to make an informed judgment about BlueLincs' voluntary review process.

BlueLincs will not charge you any fees or costs as a part of the voluntary review process. If you elect to pursue your voluntary review rights, any statute of limitations or other defense based on timeliness will be tolled during the time that any voluntary review is pending.

BlueLincs cannot claim that you failed to exhaust the administrative remedies available to you for failing to submit the benefit dispute to BlueLincs' voluntary review process.

To request a Level II reconsideration of your benefit determination, you should submit your request in writing to the following address:

Member Appeal Coordinator – Member Services Department
BlueLincs HMO
P. O. Box 21128
Tulsa, OK 74121-1128

The written request should include your name, your BlueLincs identification number, the nature of the complaint, the facts upon which the complaint is based, **and the resolution you are seeking**. Necessary facts are: dates and places of services, names of Providers of services, place of hospitalization and types of services or procedures received (if applicable). You should include any documentation, including medical records, that you want to become a part of the review file. BlueLincs may request further information if necessary.

Within seven working days following BlueLincs' receipt of a Level II request, you will receive a written notification outlining your rights and the time frames for determination.

A Request Involving Urgent Care may be appealed by contacting Member Services at 1-800-580-6202.

Your voluntary review will be directed to the BlueLincs Grievance Committee. The purpose of this committee is to protect your rights and to provide a mechanism to review and resolve issues that are not resolved to your satisfaction through the Level I appeal process. This committee is comprised of representatives of functional areas of BlueLincs, internal medical staff, external Physicians and insured Members who are not employed by BlueLincs. A review of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational or not Medically Necessary or appropriate, will be referred to a health care professional who has appropriate training and experience in the applicable field of medicine.

The committee's determination will be made within 60 days following receipt of your request, unless, in BlueLincs' opinion, additional time is needed to complete the review. In such case, BlueLincs will issue written notice, on or before the 60th day, advising you of an extension, not to exceed 60 days. Written notice of the committee's determination will be issued to you.

Level III – Additional Rights

For services that are denied as not Medically Necessary, medically appropriate or medically effective, Oklahoma law gives you the right to an eternal review by an independent review organization. If requested, BlueLincs will notify you, n writing, of the procedure to obtain an external review as set forth in the Oklahoma Managed Care External Review Act.

Please keep in mind that you are not obligated by the Plan to pursue Levels II or III voluntary reviews in any specific order, nor to exhaust Levels II or III voluntary reviews, before bringing a civil action. If these review processes do not provide a satisfactory resolution to your claim for benefits, legal remedies are available, including pursuing your claim in court.

Your ERISA Rights

As a participant in this Plan, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Check with your Group Administrator to see if your Plan is governed by ERISA.

ERISA Rights

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator (your Employer) to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain

certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Definitions

Actively at Work

The active expenditure of time and energy in the services assigned by the Employer. An Employee is deemed to be Actively at Work on each day of a regular paid vacation, sick leave, an Employer holiday or on a regular nonworking day, if such Employee was Actively at Work on the work day preceding his or her Effective Date.

Agreement

The Group Master Agreement (including the Group Application, Schedule of Benefits and any attachments and/or riders) issued to the Employer by BlueLincs.

Agreement Anniversary Date

The date the Agreement renews and each 12-consecutive-month renewal date thereafter.

Agreement Effective Date

The date the Agreement between the Employer and BlueLincs begins.

Alternate Health Plan

An indemnity or traditional group health insurance plan provided to eligible Employees of the Employer, whether fully insured or self-insured by the Employer.

Annual Transfer Period

The 31-day period immediately before the Group's Agreement Anniversary Date in which an Eligible Person who has coverage through the Employer's Alternate Health Plan can apply to transfer the coverage to the Agreement.

Benefit Period

The specified period of time during which charges for Covered Services must be Incurred in order to be eligible for payment by BlueLincs. A charge shall be considered Incurred on the date the service or supply was provided to a Member. Benefit Period shall mean a Calendar Year.

BlueCard

A program which offers access to out-of-town care through Participating Blue Cross and Blue Shield HMOs located across the country. It is intended to supplement the out-of-area coverage that is currently offered.

Calendar Year

The period of 12 months commencing on the first day of January and ending on the last day of the following December.

Certificate of Coverage

A document providing information which is intended to enable an individual to establish his/her Creditable Coverage for the purposes of reducing any preexisting condition exclusion imposed on the individual by any subsequent Group Health Plan coverage.

COBRA Continuation Coverage

Coverage under a Group Health Plan that satisfies the provisions of COBRA (Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended).

Coinsurance

The percentage of Prescription Drug charges for which the Member is responsible.

Copayment

An amount a Member must pay in connection with the delivery of Covered Services.

Covered Service

A service or supply a Member receives from a Provider and for which BlueLincs will provide benefits according to the Agreement.

Creditable Coverage

Coverage provided for you from a wide range of sources, including Group Health Plans, individual health insurance coverage, COBRA Continuation Coverage, Medicare and Medicaid.

Custodial Care

Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury or condition. Custodial Care includes, but is not limited to: help in walking, bathing, dressing, feeding; preparation of special diets; and supervision over self-administration of medications not requiring constant attention of trained medical personnel.

Deductible

A specified dollar amount of Covered Services that the Member must incur before BlueLincs will start to pay its share of the remaining Covered Services.

- Subscriber Only Coverage: When the Deductible specified in the Schedule of Benefits is reached, no additional Deductible will be required for Covered Services Incurred by the Member during the remainder of the Benefit Period.

- Dependent Coverage: When a family enrolled under Dependent coverage reaches the family Deductible specified in the Schedule of Benefits, no additional Deductible will be required for Covered Services Incurred by any Members under the same Dependent coverage during the remainder of the Benefit Period.

Dependent

Any person in a Subscriber's family who meets the eligibility requirements of the Agreement.

Durable Medical Equipment

Items which can withstand repeated use, meet BlueLincs' criteria of Medical Necessity for the given diagnosis, are not useful to the patient in the absence of illness, injury or disease, and are appropriate for use in the patient's home.

Effective Date

The date when a Member's coverage begins.

Eligible Person

A person entitled to apply to be a Subscriber as specified in the Eligibility, Enrollment, Changes and Termination section.

Emergency Care

Treatment for an injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

- serious jeopardy to the Member's health;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

Employee

An Eligible Person as specified in the Eligibility, Enrollment, Changes and Termination section.

Employer

A Group, as defined, in which there exists an employment relationship between a Subscriber and the Group.

Enroll

To become covered for benefits under the Agreement (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to Enroll for coverage.

Experimental/Investigational

A drug, device, biological product, or medical treatment or procedure is Experimental or Investigational if **BlueLincs determines** that:

- The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or

- The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

- The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Family Coverage

Coverage for the Subscriber and one or more of the Subscriber's Dependents.

Full-Time Student

A person who is regularly attending an accredited secondary school, college or university as:

- an undergraduate student enrolled in 12 or more semester hours, or the academic equivalent; or
- a graduate student enrolled in nine or more semester hours, or the academic equivalent; or
- a graduate assistant student enrolled in six or more semester hours, or the academic equivalent.

Group

A number or group of Subscribers who are employed by the Employer, who have been accepted by BlueLincs for coverage and whose premiums are remitted to BlueLincs by the Employer.

Group Health Plan

A plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

Health Maintenance Organization (HMO)

An organized system of health care that provides a comprehensive package of health services, through Participating Providers, to a voluntarily enrolled membership, within a particular geographic area.

Home Health Care Agency

An organization certified as a Home Health Care Agency under federal Medicare law, or otherwise approved by BlueLincs for the delivery of non-Physician patient care in the home of a Member.

Hospital

A licensed general Hospital which is listed as a general Hospital by the American Hospital Association or the American Osteopathic Hospital Association and that is primarily engaged in providing diagnostic and therapeutic facilities of the surgical and medical diagnosis, treatment and care of injured and sick persons, by or under the supervision of a staff of Physicians who are duly licensed to practice medicine and surgery, and which continuously provides 24-hour a day nursing services by registered graduate nurses.

Hospital Services

Services for registered bed patients or Outpatients.

Incurred

An expense is Incurred on the date a Member receives the service or supply for which the charge is made.

Initial Enrollment Period

The 31-day period immediately following the date an Employee or Dependent first becomes eligible to Enroll for coverage under the Agreement.

Inpatient

A Member who is treated as a registered bed patient in a Hospital or Skilled Nursing Facility and for whom room and board charge is made.

Late Enrollee

An individual who Enrolls under the Agreement at a time other than during:

- the Initial Enrollment Period; or
- a Special Enrollment Period for the individual.

Medical Group

A Medical Group which has entered into a contractual agreement with BlueLincs for the provision of services to Members on an agreed upon basis.

Medical Group Managed Care Committee

A group of Medical Group Participating Physicians charged with reviewing the appropriateness and Medical Necessity of health care treatment decisions made by Medical Group Participating Providers.

Medical Group Network

The group of Providers (including Physicians, Specialists, Hospitals and other professionals who provide health care services to BlueLincs Members) affiliated with the same Medical Group as the Member's Primary Care Physician.

Medical Services

Those professional services of Physicians, and paramedical personnel, including medical, surgical, diagnostic, therapeutic and preventive services.

Medically Necessary (or Medical Necessity)

- Services or supplies provided by a Hospital, Physician or other Provider that BlueLincs determines are:

- appropriate for symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury; and

- in accordance with standards of good medical practice; and

- not primarily for the convenience of the Member or the Member's Provider; and

- the most appropriate supply or level of service that can safely be provided to the Member. When applied to hospitalization, this means that the Member requires acute care as a bed patient due to the nature of the services rendered or the Member's condition and the Member cannot receive safe or adequate care as an Outpatient.

Medicare

The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965 and amendments.

Member

Any Subscriber or Dependent eligible for and enrolled for BlueLincs services.

Mental Illness

An emotional or mental disorder in which a person's thoughts, feelings or actions are abnormally disturbed, regardless of whether the condition or causation has a physical or emotional (mental) basis.

Open Enrollment Period

A period of 31 days immediately preceding the Group's Agreement Anniversary Date (renewal date) during which an individual who previously declined coverage may Enroll for coverage under the Agreement as a Late Enrollee.

Out-of-Pocket Maximum

The total amount of Copayments to be paid by the Member and the Member's Dependents during a Calendar Year.

- Subscriber Only Coverage. When the Out-of-Pocket Maximum specified in the Schedule of Benefits is reached, no additional Copayments will be required for Covered Services Incurred by the Member during the remainder of the Calendar Year.

- Family Coverage. When each of three Members under the same Family Coverage reaches the Out-of-Pocket Maximum specified in the Schedule of Benefits, no additional Copayments will be required for Covered Services Incurred by any Members under that same Family Coverage during the remainder of the Calendar Year.

The following services do not count toward the Out-of-Pocket Maximum:

- Inpatient Mental Services or Alcohol and Drug Abuse Services; or
- Nonauthorized services rendered by a nonparticipating Provider; or
- Prescription Drugs purchased at a retail pharmacy; or
- Self-Referral Services; or
- Services which are applied toward the Deductible; or
- Other supplemental benefits (including Vision).

Outpatient

A Member who receives services or supplies during a visit to the Hospital which lasts less than 24 hours and who is not registered as Inpatient.

Participating Provider (Physician, Specialist, Hospital, Home Health Care Agency, Pharmacy, Skilled Nursing Facility, other health care professionals, etc.)

Any Provider of health care services that has entered into a contractual agreement with BlueLincs for the provision of services to Members.

Participating Retail Pharmacy

A pharmacy that has entered into a Participating Pharmacy Agreement with BlueLincs.

Physician

A doctor of Medicine, Osteopathy or other healing art profession defined and authorized by Oklahoma statutes, who is duly licensed to practice as such and is in good standing with the Oklahoma Board of Osteopathic Examiners or other Oklahoma Board of Physician Examiners appropriate to the specified healing art profession.

Placement for Adoption (or Placed for Adoption)

The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person terminates upon the termination of such legal obligation.

Preauthorization/Precertification

The process of requiring Participating Providers or Medical Group Participating Providers to obtain authorization from a Member's Primary Care Physician and/or BlueLincs and/or the Medical Group's Managed Care Committee prior to scheduling all non-primary care Medical Services (excluding Emergency Care).

Prescription Drug

Any medicinal substance required by the Federal Food, Drug and Cosmetic Act to bear the following legend on its label: "Caution: Federal Law prohibits dispensing without prescription."

Prescription Drug does not include maintenance Prescription Drugs labeled Schedule II, Schedule III, Schedule IV or Schedule V drugs by the U. S. Department of Justice, Drug Enforcement Administration, or any other Prescription Drug used for its psychotropic, antidepressant or antianxiety effects.

Prescription Order

A written order, and each refill, for a Prescription Drug issued by a Participating Physician.

Primary Care Physician (PCP)

A Physician who provides primary care Medical Services as a general or family care practitioner, or in some cases as an internist or pediatrician, and who has contracted with BlueLincs to provide primary care Medical Services to Members.

Properly Filed Claim

A formal statement or claim regarding a loss which provides sufficient, substantiating information to allow BlueLincs to determine its liability for Covered Services. This includes: a completed claim form; the Provider's

itemized statement of services rendered and related charges; and medical records, when required by BlueLincs.

Provider

A Physician, Hospital, Skilled Nursing Facility, Home Health Care Agency or other Provider as determined by BlueLincs.

Qualifying Event

Any one of the following events, which, but for the COBRA Continuation Coverage provisions described in this Member Handbook, would result in the loss of a Member's coverage:

The death of the covered Employee;

- The termination (other than by reason of a covered Employee's gross misconduct), or reduction of hours, of the covered Employee's employment;
- The divorce or legal separation of the covered Employee from the Employee's spouse;
- The covered Employee becoming entitled to benefits under Medicare;
- A Dependent child ceasing to be eligible.

Self-Referral Services

Services which are not provided or authorized in advance by the Member's Primary Care Physician (PCP).

Service Area

The geographic area in which BlueLincs is licensed by the Oklahoma Insurance Department to provide health care services. A Member may call the BlueLincs Member Services Department at 1-800-580-6202 to determine if he or she is in the Service Area or log on to the Web site at www.bcbsok.com.

Skilled Home Health Care Services

Services provided by a Home Health Care Agency on a part-time, intermittent basis when a Member is confined to his or her home because of disease or injury.

Skilled Nursing Facility

A Provider which is primarily engaged in providing skilled nursing and related services on an Inpatient basis to patients requiring 24-hour skilled nursing services but not requiring confinement in an acute care general Hospital. Such care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- minimal care, Custodial Care, ambulatory care, or part-time services; or

- care or treatment of Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis.

Special Enrollment Period

A period during which an individual who previously declined coverage is allowed to Enroll under the Agreement without having to wait until the Group's next regular Open Enrollment Period.

Specialist

A Physician who provides Medical Services in any generally accepted medical specialty or sub-specialty, or a Physician licensed in any duly recognized special healing arts discipline who provides health care and services generally accepted within the scope of the Physician's license.

Subscriber

An eligible Employee of the Employer who is enrolled for coverage.

Total Disability (or Totally Disabled)

A condition resulting from disease or injury in which, as certified by a Physician:

- A Member is unable to perform the substantial duties of any occupation or business for which he/she is qualified and the Member is not in fact engaged in any occupation for wages or profit; or

- If the Member does not usually work for wages or profit, the Member cannot do the normal activities of a person of the same age and sex.

BlueLincs reserves the right to review a Physician's certificate of disability and/or request medical records and/or require a medical examination by an independent Physician to verify disability at the Member's expense. BlueLincs will make the final determination as to whether the Member is Totally Disabled.

Urgent Care

Treatment for an unexpected illness or injury that is not an emergency, but which is severe or painful enough to require treatment within 24 hours. Examples include, but are not necessarily limited to: lacerations, high fever, severe vomiting and diarrhea, pulled muscles, or other similar illnesses or injuries.

RIDER REGARDING
OUTPATIENT PRESCRIPTION DRUG BENEFITS

Effective February 1, 2010, or your Effective Date, if later, your Member Handbook is amended by the addition of the following special provisions.

The ***Prescription Drug Benefits*** section of your Member Handbook, and the ***Prescription Drug Schedule of Benefits*** **(if applicable)** are amended as set forth below:

- **SPECIAL DEFINITIONS**

  The following definitions shall apply and/or have special meaning for the purpose of the benefits provided under this ***Prescription Drugs Schedule of Benefits***:

  – **Retail Pharmacy Vaccination Network** – A network of Participating Pharmacies that have certified vaccination Pharmacists on staff who have contracted to administer vaccinations to Members.

  – **Specialty Pharmacy Drugs** – Prescription Drugs that meet at least two of the following criteria:

    - they are high cost;
    - they are for use in limited patient populations or indications;
    - they are typically self-injected;
    - they have limited availability, require special dispensing, or delivery and/or patient support is required and, therefore, they are difficult to obtain via traditional Pharmacy channels;
    - complex reimbursement procedures are required; and/or
    - a considerable portion of the use and costs are frequently generated through office-based medical claims.

  – **Specialty Pharmacy Network –** A limited network of Participating Pharmacies that provide the following services to Members:

    - access to high-cost medications that are used in limited populations;
    - special dispensing, delivery and patient clinical support;
    - guidance through complex reimbursement procedures for Specialty Pharmacy Drugs.

- **COVERED SERVICES**

  Your Benefits are amended to include the following Covered Services:

  – Oral chemotherapy when prescribed by a licensed Physician.

  – Self-injectable Prescription Drugs (including chemotherapy) when dispensed by a Pharmacy. Self-injectable drugs purchased from a Physician and administered in his/her office are not covered.

  – Specialty Pharmacy Drugs **(**when dispensed by a Pharmacy participating in the Specialty Pharmacy Network), **limited to a 30-day supply per Prescription Order**.

- Vaccinations (when administered by a Participating Retail Pharmacy Vaccination Network Provider). Visit the Blue Cross and Blue Shield of Oklahoma Web site at www.bcbsok.com for a current listing of vaccines available through this program.

- **BENEFITS**
  - Benefits for oral chemotherapy, self-injectable Prescription Drugs and Specialty Pharmacy Drugs are subject to the Copayment, Coinsurance and/or Deductible provisions specified in the ***Prescription Drug Schedule of Benefits***.
  - Benefits for Specialty Pharmacy Drugs dispensed by a Pharmacy that is not a member of the Specialty Pharmacy Network are limited to a three-day supply per Prescription Order, and are available only in the following instances:
    - you are outside the Service Area and the Physician orders the Specialty Pharmacy Drug to treat a covered emergency condition (as determined by BlueLincs HMO); or
    - your Primary Care Physician orders immediate use of a Specialty Pharmacy Drug due to a Medical Necessity and no Participating Specialty Pharmacy is open.
  - Vaccinations administered by a Participating Retail Pharmacy Vaccination Network Provider are subject to a $15 Copayment, after satisfaction of the Prescription Drug Deductible, if applicable. **Vaccinations administered by a Pharmacy that is not a Participating Retail Pharmacy Vaccination Network Provider are not covered under the *Prescription Drug Schedule of Benefits*.**

- **BRAND NAME EXCLUSION**

  Some equivalent drugs are manufactured under multiple brand names and have many therapeutic equivalents. In such cases, BlueLincs HMO may limit benefits to only one of the brand or therapeutic equivalents available. If you do not accept the brand or therapeutic equivalent that is covered under your Prescription Drug program, the drug purchased will not be covered under any benefit level.

- **PHARMACY DISCOUNT PROGRAMS**

  In an effort to help offset the rising cost of Prescription Drugs, drug manufacturers may offer coupons or other drug discounts or rebates to Members, which may impact the benefits provided under this program. The total benefits payable will not exceed the balance of the allowable charges remaining after all drug coupons, rebates or other drug discounts have been applied. You agree to reimburse BlueLincs HMO any excess amounts for benefits that we have paid and for which you are not eligible due to the application of drug coupons, rebates or other drug discounts.

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Except as amended, your Member Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR MEMBER HANDBOOK FOR FUTURE REFERENCE.

RIDER REGARDING
REFERRALS, ELIGIBILITY, COVERED SERVICES, EXCLUSIONS, RIGHT OF RECOUPMENT AND DEFINITIONS

Your Member Handbook is amended by the addition of the following special provisions. Unless otherwise specifically stated in this Rider, or as required by federal or state regulation, the provisions of this notice are effective February 1, 2010, or your Effective Date, whichever is later.

- **AMENDMENT REGARDING BLUELINCS REFERRALS**

  The ***How BlueLincs Works*** section is amended as follows:

  – **Changing Your PCP**

  You may change your PCP up to four times per year. To change your PCP, call or write Member Services. **Requests must be received no later than the 20th day of the month to be effective on the first day of the following month.** Changes are subject to PCP availability. Your new PCP is responsible for your care as of the Effective Date. You should schedule a welcome visit with your new PCP to discuss your health care needs as soon as possible.

  – **Medical Group Networks**

  When you choose your PCP, you are also choosing a specific Medical Group Network. Many of BlueLincs' PCPs are with a specific Medical Group or clinic, which includes Specialists, Hospitals and other health care professionals. If your PCP is with a Medical Group or clinic, your PCP will likely coordinate referrals through his or her group of Specialists, and referrals may be reviewed by their own Managed Care Committee.

  – **Well Woman Examinations**

  You do not need a referral to see a BlueLincs participating Provider for your annual "well woman" exam. This exam includes a pap smear, a pelvic exam and an occult blood lab once every twelve months. Routine mammograms are also covered without a referral, subject to the limits shown in the Schedule of Benefits. Any follow-up care required after your routine "well woman" exam (including mammography screening) must be coordinated by your PCP. If you need additional specialty care, your PCP will refer you to a BlueLincs participating Provider within the BlueLincs HMO Network.

  – **Well Man Examinations**

  You do not need a referral to see a BlueLincs participating urologist for your annual "well man" exam. This exam includes an office visit, a prostate exam and an occult blood lab once every twelve months**.** Any follow-up care required after your routine "well man" exam (including a PSA test) will be coordinated by your PCP. If you need additional specialty care from a urologist, your PCP will refer you to a BlueLincs participating urologist within the BlueLincs HMO Network.

- **AMENDMENT REGARDING ELIGIBLE PERSONS**

  The ***Eligibility, Enrollment, Changes & Termination*** section is amended as follows:

  You are an Eligible Person if you reside or work in the BlueLincs Service Area and you satisfy the eligibility requirements specified by your Employer, as set forth in the Group Contract.

- **AMENDMENT REGARDING DEPENDENT ELIGIBILITY**

  The ***Eligibility, Enrollment, Changes & Termination*** section is amended by the addition of the following special provisions under the heading "**Who Is an Eligible Dependent**":

  Coverage will continue under this Member Handbook for an unmarried Dependent who is unable to maintain Full-Time Student status as a result of a medically necessary leave of absence or any other change in enrollment, provided that:

  – The Dependent is enrolled on the basis of being a student at a postsecondary education institution; and

  – The Dependent was covered immediately before the first day of the medically necessary leave of absence or other change in enrollment; and

  – The Dependent child's treating Physician provides to BlueLincs a written certification stating that the child is suffering from a serious illness or injury and that the leave of absence or other change in enrollment is medically necessary.

  Coverage for such a Dependent may be continued under the Member Handbook until the date that is the earlier of:

  – One year after the first day of the medically necessary leave of absence or other change in enrollment; or

  – The date on which such coverage would otherwise terminate under the terms of the Member Handbook.

  The first day of the medically necessary leave of absence will be documented as the date indicated by the Physician in the written certification on which the medical leave or other enrollment change is to begin.

- **AMENDMENT REGARDING SPECIAL ENROLLMENT RELATED TO MEDICAID AND CHILD HEALTH INSURANCE PROGRAM (CHIP) COVERAGE**

  The ***Eligibility, Enrollment, Changes & Termination*** section is amended by the addition of the following special provisions under he heading "**Special Enrollment Periods**":

  Effective April 1, 2009, a 60-day Special Enrollment Period occurs when Employees and Dependents who are eligible but not enrolled for coverage in the Group Health Plan experience either of the following qualifying events:

  – The Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or

  – The Employee or Dependent becomes eligible for a Group Health Plan premium assistance subsidy under Medicaid or CHIP.

  An Employee must request this special enrollment into the Group Health Plan within 60 days of the loss of Medicaid or CHIP coverage, and within 60 days of the Employee or Dependent becoming eligible for a Group Health Plan premium assistance subsidy under Medicaid or CHIP. Coverage

under special enrollment will be effective no later than the first day of the month after BlueLincs receives the special enrollment request.

- **AMENDMENT REGARDING OUTPATIENT THERAPY SERVICES**

  The Benefits specified in the ***Schedule of Benefits*** for "**Outpatient Physical Therapy"** and **"Outpatient Occupational Therapy"** shall include Covered Services provided during a visit to the Member's home, as well as visits to the Provider's office or other Outpatient visits.

- **AMENDMENT REGARDING PSYCHIATRIC CARE SERVICES**

  – The ***Schedule of Benefits*** is amended so that the benefits listed for Mental Illness Services and Alcohol and Drug Abuse Services shall include treatment provided by a Hospital, Psychiatric Hospital, Residential Treatment Center or other BlueLincs-approved Provider.

  – The ***Definitions*** section is amended by the addition of the following paragraph:

    ○ **PSYCHIATRIC HOSPITAL** – a Provider that is a state licensed hospital that primarily specializes in the treatment of severe Mental Illnesses and/or substance abuse disorders.

    ○ **RESIDENTIAL TREATMENT CENTER** – a state licensed and/or state certified facility that provides a 24-hour level of residential care to patients with long-term or severe Mental Illnesses and/or substance abuse disorders. This care is medically monitored, with 24-hour Physician availability and 24-hour onsite nursing services.

- **AMENDMENT REGARDING EXCLUSIONS**

  The **"Exclusions and Limitations"** set forth in the ***Schedule of Benefits*** are amended as set forth below:

  – The following exclusions are hereby removed:

    ○ For drug and alcohol treatment that is not rendered in a Hospital or by a psychiatrist, psychologist, licensed clinical social worker or person with a master's degree in social work.

    ○ For services rendered by licensed professional counselors, marital and family therapists or counselors, or licensed drug and alcohol counselors.

  – The following exclusions are hereby added:

    ○ For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.

    ○ For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.

    ○ Oral chemotherapy or self-injectable chemotherapy, except as may be covered by a supplemental Prescription Drug Schedule of Benefits.

- **AMENDMENT REGARDING RIGHT OF RECOUPMENT**

  The ***Other Coverage and Right of Recoupment*** section is amended by the addition of the following provision under "**Right of Recoupment**":

  BlueLincs HMO expressly disclaims all make whole and common fund rules and doctrines and any other rule or doctrine that would impair or interfere with BlueLincs HMO's rights herein.

- **AMENDMENT REGARDING MEDICAL NECESSITY**

  The ***Definitions*** section is amended so that the definition of "Medically Necessary (or Medical Necessity)" is hereby deleted and replaced by the following definition:

  Medically Necessary (or Medical Necessity) – health care services that a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

  – in accordance with generally accepted standards of medical practice;

  – clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

  – not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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Except as amended, your Member Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR MEMBER HANDBOOK FOR FUTURE REFERENCE.

RIDER REGARDING BENEFITS FOR AUTISM AND AUTISM SPECTRUM DISORDERS

Effective on your Group's first renewal date coinciding with or next following January 1, 2010 (or your Effective Date, if later), your Member Handbook is amended by the addition of the following special benefit provisions.

- Subject to the Exclusions, conditions, and limitations of this Member Handbook, benefits will be provided for the treatment of autism and autism spectrum disorders, in accordance with the following special provisions:

  SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS

  Evaluation and management procedures, including speech therapy, physical therapy and occupational therapy, for treatment of autism and autism spectrum disorders, ***limited to the following diagnoses***:

  – Autistic disorder — childhood autism, infantile psychosis and Kanner's syndrome;

  – Childhood disintegrative disorder — Heller's syndrome;

  – Rhett's syndrome; and

  – Specified pervasive developmental disorders — Asperger's disorder, atypical childhood psychosis and borderline psychosis of childhood.

  Speech therapy, physical therapy and occupational therapy visits related to treatment of autism or autism spectrum disorders are not subject to the limitations specified under "**Special Services**" as set forth in the ***Schedule of Benefits***.

  Benefits for treatment of autism and autism spectrum disorders are limited to Members under six years of age and shall be further limited to a maximum of:

  ○ **$25,000 per Benefit Period per Member; and**

  ○ **$75,000 per lifetime per Member.**

- Benefits for the treatment of autism and autism spectrum disorders shall be subject to the same provisions regarding:

  – Copayment and/or Coinsurance provisions set forth in the ***Schedule of Benefits*** for Covered Services (including the Copayment/Coinsurance amounts specified for Physician Services, physical therapy, occupational therapy and speech therapy); and

  – The Deductible amount, if any, specified in the ***Schedule of Benefits***; and

  – Preauthorization/Precertification and utilization review mechanisms as applicable to all Covered Services.

- The "**Exclusions and Limitations**" set forth in the ***Schedule of Benefits*** are amended by the addition of the following exclusions:

  – Services, supplies or charges related to unspecified developmental disorders or autistic disease of childhood, except as specified in this rider.

  – Services, supplies or charges related to applied behavior analysis.

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Except as amended, your Member Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR MEMBER HANDBOOK FOR FUTURE REFERENCE.

RIDER REGARDING
ELIGIBILITY, TERMINATION OF COVERAGE, COBRA CONTINUATION COVERAGE AND CONVERSION COVERAGE

Effective January 1, 2008 (or your Effective Date, if later), the ***Eligibility, Enrollment, Changes & Termination*** provisions of your Member Handbook are amended as set forth below.

- **Newborn Children**

  The provisions regarding "Newborn Children" are amended by deleting the stipulation that contributions for newborn children must be made from the date of birth. Subscriber contributions for newborn children, when required, must be made in accordance with the billing practices established for the Group.

- **Deleting a Dependent**

  You can change your coverage to delete Dependents. The change will be effective at the end of the coverage period during which eligibility ceases.

- **Delayed Effective Date**

  The "Actively at Work" provision shall not apply to an Eligible Person who is absent from work due to a health status factor.

- **When Coverage Under This Certificate Ends**

  When a Subscriber is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the coverage period during which eligibility ceases, except as follows:

  – A Subscriber's COBRA Continuation Coverage, when applicable, will cease on the earliest to occur of the following dates:

    ○ the date the coverage period ends following expiration of the 18-month, 29-month, or 36-month COBRA Continuation Coverage period, whichever is applicable;

    ○ the first day of the month that begins more than 30 days after the date of the Social Security Administration's final determination that the Subscriber is no longer disabled (when

coverage has been extended from 18 months to 29 months due to disability);

- the date on which the Group stops providing any group health plan to any Employee;
- the date on which coverage stops because of a Subscriber's failure to pay to the Group any premiums required for the COBRA Continuation Coverage;
- the date on which the Subscriber first becomes (after the date of the election) covered under any other Group Health Plan which does not contain any exclusion or limitation with respect to a Preexisting Condition applicable to the Subscriber (or the date the Subscriber has satisfied the Preexisting Condition Exclusion period under that plan); or
- the date on which the Subscriber becomes (after the date of the election) entitled to benefits under Medicare.

Your coverage will terminate retroactive to your Effective Date if you or the Group commits fraud or intentional misrepresentation in applying for or obtaining coverage under the Group Contract. Your coverage will end immediately if you file a fraudulent claim.

If your required premiums are not paid, your coverage will stop at the end of the coverage period for which your premiums have been paid.

Termination of the Group Contract automatically ends all of your coverage at the same time and date. It is the responsibility of your Group to tell you of such termination.

- **Conversion Privilege After Termination of Group Coverage**

  Written application for a conversion contract must be received by Blue Cross and Blue Shield of Oklahoma no later than 31 days after the date the Subscriber's coverage terminates.

- **COBRA Continuation Coverage**

  This provision may not apply to your Group's coverage. Please check with your Group Administrator to determine if your Group is subject to COBRA regulations, in accordance with the

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

- **COBRA Continuation Coverage Period**

  You and/or your Eligible Dependents are eligible for coverage to continue under your Group's coverage for a period not to exceed:

  - 18 months from the date of a loss in coverage resulting from a Qualifying Event involving your termination of employment or reduction in working hours; or
  - 36 months from the date of a loss in coverage resulting from a Qualifying Event involving
    - your death, divorce or legal separation, or entitlement to Medicare benefits;
    - or the ineligibility of your Dependent child;

    provided the premiums are paid for the coverage as required.

- **Disability Extension**

  - COBRA Continuation Coverage may be extended from 18 months to 29 months for you or an Eligible Dependent who is determined by the Social Security Administration to have been disabled on the date of a Qualifying Event, or within the first 60 days of COBRA Continuation Coverage. This 11-month disability extension is also available to nondisabled family members who are entitled to COBRA Continuation Coverage.
  - To request the 11-month disability extension, you or your Dependent must give notice of the disability determination to the Employer before the end of the initial 18-month COBRA Continuation Coverage period, and no later than 60 days after the date of the Social Security Administration's determination. In addition, you or your Dependent must notify the Employer within 30 days after the Social Security Administration makes a determination that you or your Dependent is no longer disabled.

– **Multiple Qualifying Events**

In the event an Eligible Dependent experiences a second Qualifying Event after onset of COBRA Continuation Coverage resulting from your termination or reduction in work hours, the maximum period of coverage is 36 months from the date of a loss in coverage resulting from the first Qualifying Event. This extension is available to the Eligible Dependent only.

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Except as amended, your Certificate/Booklet remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR CERTIFICATE/ BOOKLET FOR FUTURE REFERENCE.

SPECIAL NOTICE REGARDING HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

Your BlueLincs HMO Member Handbook, including its Schedules of Benefits, is amended so that the **"Human Organ, Tissue and Bone Marrow Transplant Services"** provisions are deleted in their entirety and replaced by the following:

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

All transplants are subject to Precertification and must be performed in and by a Provider that meets the criteria established by BlueLincs HMO for assessing and selecting Providers for transplants.

Precertification must be obtained at the time the Member is referred for a transplant consultation and/or evaluation. It is the Member's responsibility to make sure Precertification is obtained. Failure to obtain Precertification will result in denial of Benefits. BlueLincs HMO has the sole and final authority for approving or declining requests for Precertification.

DEFINITIONS

In addition to the definitions listed under the Definitions section of the Member Handbook, the following definitions shall apply and/or have special meaning for the purpose of this amendment:

- **Bone Marrow Transplant**

  A medical and/or surgical procedure comprised of several steps or stages including:

  – the harvest of stem cells or progenitor cells, whether from the bone marrow or from the blood, from a third-party donor (allogeneic transplant) or from the patient (autologous transplant);

  – processing and/or storage of the stem cells or progenitor cells after harvesting;

  – the administration of High-Dose Chemotherapy and/or High-Dose Radiation Therapy, when this step is prescribed by the treating Physician;

  – the infusion of the harvested stem cells or progenitor cells; and

– hospitalization, observation and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts.

The above definition of autologous Bone Marrow Transplant specifically includes transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvested directly from the bone marrow, a procedure commonly known as peripheral stem cell or progenitor cell transplant or rescue procedure. This definition further specifically includes all component parts of the procedure including, without limitation, the High-Dose Chemotherapy and/or High-Dose Radiation Therapy.

- **Experimental/Investigational**

  A drug, device, biological product, or medical treatment or procedure is Experimental or Investigational if **BlueLincs HMO determines** that:

  – The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or

  – The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

  – The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis

  - **High-Dose Chemotherapy**

    A form of Chemotherapy wherein the dose exceeds standard doses of Chemotherapy to the extent that virtually all patients who receive High-Dose Chemotherapy sustain destruction of the bone marrow to the point that bone marrow or peripheral stem cells or progenitor cells must be implanted or infused to keep the patient alive.

- **High -Dose Radiation Therapy**

  A form of Radiation Therapy wherein the dose exceeds standard doses of Radiation Therapy resulting in destruction of the bone marrow to the point that bone marrow or peripheral stem cells or progenitor cells must be implanted or infused to keep the patient alive.

- **Precertification**

  Certification from BlueLincs HMO that, based upon the information submitted by the Member's attending Physician, Benefits will be provided under the Agreement. Precertification is subject to all conditions, exclusions and limitations of the Agreement. Precertification does not guarantee that all care and services a Member receives are eligible for Benefits under the Agreement.

- **Procurement Services**

  The services provided to search for and match the human organ, tissue, bone marrow, peripheral stem cells, or progenitor cells donated to the transplant recipient, surgically remove the organ, tissue, bone marrow, peripheral stem cells, or progenitor cells from the donor and transport the organ, tissue, bone marrow, peripheral stem cells, or progenitor cells to the location of the recipient within 24 hours after the match is made.

TRANSPLANT SERVICES

Subject to the Exclusions, conditions, and limitations of the Agreement, Benefits will be provided for Covered Services rendered by a Hospital, Physician, or other Provider for the transplant procedures set forth below.

- Musculoskeletal transplants;
- Parathyroid transplants;
- Cornea transplants;
- Heart-valve transplants;
- Kidney transplants;
- Heart transplants;
- Single lung, double lung and heart/lung transplants;
- Liver transplants;
- Intestinal transplants;
- Small bowel/liver or multivisceral (abdominal) transplants;

- Pancreas transplants;
- Islet cell transplants;
- Bone Marrow Transplants.

EXCLUSIONS AND LIMITATIONS APPLICABLE TO ORGAN/TISSUE/BONE MARROW TRANSPLANTS

- The transplant must meet the criteria established by BlueLincs HMO for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in BlueLincs HMO's written medical policies.
- In addition to the Exclusions set forth elsewhere in the Agreement and the Member Handbook, no Benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:
  - Adrenal to brain transplants.
  - Allogeneic islet cell transplants.
  - High-Dose Chemotherapy or High-Dose Radiation Therapy if the associated autologous or allogeneic Bone Marrow Transplant, stem cell or progenitor cell treatment or rescue is not a Covered Service.
  - Small bowel transplants using a living donor.
  - Any organ or tissue transplant or Bone Marrow Transplant from a non-human donor or for the use of non-human organs for extracorporeal support and/or maintenance.
  - Any artificial device for transplantation/implantation, except in limited instances as reflected in BlueLincs HMO's written medical policies.
  - Any organ or tissue transplant or Bone Marrow Transplant procedure which BlueLincs HMO considers to be Experimental or Investigational in nature.
  - Expenses related to the purchase, evaluation, procurement services, or transplant procedure if the organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Member recipient.
  - All services, provided directly for or relative to any organ or tissue transplant, or Bone Marrow Transplant procedure which is not specifically listed as a Covered Service in this amendment.
- The transplant must be performed in and by a Provider that meets the criteria established by BlueLincs HMO for assessing and selecting Providers in the performance of organ or tissue transplants, or Bone Marrow Transplant procedures.

DONOR BENEFITS

If a human organ, tissue or Bone Marrow Transplant is provided from a ***living*** donor to a human transplant recipient:

- When both the recipient and the living donor are Members, each is entitled to the Benefits of the Agreement.
- When only the recipient is a Member, both the donor and the recipient are entitled to the Benefits of the Agreement. The donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program. Benefits provided to the donor will be charged against the recipient's coverage under the Agreement.
- When only the living donor is a Member, the donor is entitled to the Benefits of the Agreement. The Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program available to the recipient. There are no Covered Services for the non-Member transplant recipient.
- If any organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Member recipient, no Covered Services will be provided for the purchase price, evaluation, procurement services or procedure.
- BlueLincs HMO is not liable for transplant expenses incurred by donors, except as specifically provided.

RESEARCH–URGENT BONE MARROW TRANSPLANT BENEFITS WITHIN NATIONAL INSTITUTES OF HEALTH CLINICAL TRIALS ONLY

Bone Marrow Transplants that are otherwise excluded by the Agreement as Experimental or Investigational (see Definitions and Exclusions) are eligible for benefits if the Bone Marrow Transplant meets all of the following criteria:

- It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is life threatening and that has a poor prognosis with the most effective conventional treatment. For purposes of this provision, a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed, or are not medically appropriate;

- The Bone Marrow Transplant is available to the Member seeking it and will be provided within a clinical trial conducted or approved by the National Institutes of Health;
- The Bone Marrow Transplant is not available free or at a reduced rate; and
- The Bone Marrow Transplant is not excluded by another provision of the Agreement.

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This amendment is effective on January 1, 2008 (or your Effective Date, if later). It supersedes any previous amendment for human organ transplant, tissue transplant and Bone Marrow Transplant services issued to you, and/or any provisions for human organ transplant, tissue transplant and Bone Marrow Transplant services currently reflected in the Agreement or your Member Handbook.

Except as amended, your Member Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR MEMBER HANDBOOK FOR FUTURE REFERENCE.

RIDER REGARDING
PRESCRIPTION DRUG BENEFITS

Effective June 1, 2007 (or your Effective Date, if later), your Member Handbook, including any Schedule of Benefits and/or Amendatory Rider applicable to Outpatient Prescription Drugs, shall be amended as set forth below:

The provisions requiring a Prescription Order to be written by a Participating Physician shall no longer apply. Benefits for Prescription Drugs (if applicable) are provided only when dispensed by a Participating Retail Pharmacy, except in emergency situations as determined by BlueLincs.

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Except as amended, your Member Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR HANDBOOK FOR FUTURE REFERENCE.

RIDER REGARDING
MEMBER CONTRIBUTIONS

Effective October 15, 2006 (or your Effective Date, if later), your Member Handbook is amended as set forth below:

The "***Eligibility, Enrollment, Changes and Termination***" provisions are amended as follows:

- The provisions regarding "Newborn Children" are amended by deleting the stipulation that Member contributions for newborn children must be made from the date of birth. Member contributions for newborn children, when required, must be made in accordance with the billing practices established for the Group.
- The section entitled, "When Coverage Under Your Plan Ends", is amended by removing the statement indicating "payment made for coverage beyond the termination date will be refunded to the Group." Adjustments in premium, if applicable, will be paid to the Group in accordance with the billing practices established for the Group.

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Except as amended, your Member Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR HANDBOOK FOR FUTURE REFERENCE.

RIDER REGARDING
BENEFITS, BENEFIT DETERMINATIONS
AND EXCLUSIONS

Effective October 15, 2006 (or your Effective Date, if later), your Member Handbook is amended as set forth below:

- **AMENDMENT RESPECTING BENEFITS FOR AUDIOLOGICAL SERVICES AND WIGS OR OTHER SCALP PROSTHESES**

  Depending upon the number of Employees in your Group Health Plan, your coverage may already include benefits for the following services. The provisions of this amendment shall supersede any amendment for Audiological Services and Wigs or Other Scalp prostheses previously issued to the Group or Member, and/or any provisions for Audiological Services and Wigs or Other Scalp Prostheses currently reflected in the Agreement or your Schedule of Benefits.

  Your Handbook is amended by the addition of the following benefits:

  – **AUDIOLOGICAL SERVICES AND HEARING AIDS**

    Benefits will be provided to Members, up to age 18, for audiological services and hearing aids, limited to every 48 months for each hearing-impaired ear; however, for children up to two years of age, up to four additional ear molds are available. Hearing aids must be prescribed, filled and dispensed by a licensed audiologist. Benefits are subject to the Deductible and/or Copayment provisions of the Group Master Agreement.

  – **WIGS OR OTHER SCALP PROSTHESES**

    Benefits shall include coverage for wigs or other scalp prostheses which are necessary for the comfort and dignity of the Member, and which are required due to hair loss resulting from radiation therapy or chemotherapy. **Benefits are limited to $150 per Benefit Period per Member.** Benefits are subject to the Deductible and/or Copayment provisions of the Group Master Agreement.

- **AMENDMENT RESPECTING BENEFITS FOR ORGAN PROCUREMENT SERVICES**

  The "***Special Benefit Provisions***" section of your Handbook is amended so that the benefits for "Human Organ, Tissue and Bone Marrow Transplant Services" shall no longer include a $15,000 benefit maximum for Procurement Services. Benefits for Procurement Services will be determined by BlueLincs in accordance with its negotiated fees for facility and professional services.

- **AMENDMENT RESPECTING BENEFIT DETERMINATIONS**

  The "***General Provisions***" section is amended by the addition of the following provisions under the "Determination of Benefits Eligibility" heading:

  In determining whether services or supplies are Covered Services, BlueLincs will determine whether a service or supply is Medically Necessary under the Agreement or if such service or supply is Experimental or Investigational. BlueLincs medical policies are used as guidelines for coverage determinations in health care benefit programs unless otherwise indicated. Medical technology is constantly evolving and these medical policies are subject to change. Copies of current medical policies may be obtained from BlueLincs upon request and may be found online at www.bcbsok.com.

- **AMENDMENT RESPECTING EXCLUSIONS**

  – The "***Schedule of Benefits***" is amended so that the exclusion for "hearing aids "is hereby deleted and replaced by the following exclusion:

    Hearing aids, except as specified for Members under age 18.

  – The "***Schedule of Benefits***" is further amended by the addition of the following exclusions:

    ○ For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.

- Ductal lavage of the mammary ducts.
- Extracorporeal shock wave treatment, also known as orthotripsy, using either a high- or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- Orthoptic training.
- Thermal capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- Transcutaneous electrical nerve stimulator (TENS).
- Drug and alcohol treatment that is not rendered in a Hospital or by a psychiatrist, psychologist, licensed clinical social worker or person with a master's degree in social work.
- Services rendered by licensed professional counselors, marital and family therapists or counselors, or licensed drug and alcohol counselors.
- Services rendered by midwives.

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Except as amended, your Member Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR HANDBOOK FOR FUTURE REFERENCE.

RIDER REGARDING
PRESCRIPTION DRUG PRECERTIFICATION PROCESS

Effective October 15, 2006 (or your Effective Date, if later), your Member Handbook is amended as set forth below:

Your Member Handbook is amended so that the Prescription Drug Precertification Process provisions are hereby deleted and restated as follows.

PRESCRIPTION DRUG PRECERTIFICATION PROCESS

BlueLincs has designated certain drugs for which you must receive Precertification in order for benefits to be provided under the Prescription Drug benefits supplement. Precertification helps to assure that your Prescription Drug meets BlueLincs' guidelines for Medical Necessity for the condition being treated.

A form of Precertification is our Step Therapy program — a "step" approach to providing benefits for certain medications your Physician prescribes for you. This means that you may first need to try one or more "prerequisite" medications before certain high-cost medications are approved for coverage under your Prescription Drug program.

If your Physician prescribes a drug requiring prior approval, you may obtain your prescription from a Participating Retail Pharmacy by following one of the following steps:

- ***You may obtain approval prior to going to the Pharmacy to have your prescription filled.***

  You can obtain a listing of the drugs which require Precertification by contacting BlueLincs Member Services at 1-800-580-6202. Or, you may request a listing by writing to:

  BlueLincs HMO
  Member Services Department
  P.O. Box 21128
  Tulsa, OK 74121-1128

  Please keep in mind that the listing of drugs requiring Precertification will change periodically as new drugs are developed or as required to assure Medical Necessity.

If your Physician prescribes a drug which requires prior approval, you or the Physician may request Precertification by calling the BlueLincs Member Services number listed above.

When you present your prescription to a Participating Retail Pharmacy, along with your BlueLincs identification card, the pharmacist will submit an electronic claim to BlueLincs to determine the appropriate benefits.

If the Precertification request is approved prior to your trip to the Participating Retail Pharmacy, your pharmacist will dispense the Prescription Drug as prescribed and collect any applicable Deductible, Copayment and/or Coinsurance amount.

If the Precertification request is denied, the pharmacist will receive an electronic message indicating that benefits are not available for the drugs. You will be responsible for the full cost of your prescription.

- ***Your Participating Retail Pharmacy may begin the Precertification process for you.***

  If you do not request approval of a drug before you go to the Participating Retail Pharmacy to have your prescription filled, your pharmacist will begin the Precertification process when you present your BlueLincs identification card with your Prescription Order. When the pharmacist submits your claim electronically, he/she will receive a message indicating that Precertification is required.

  At this point, you may request a three-day supply of the drug while BlueLincs completes the approval process. Your pharmacist will collect the appropriate Deductible, Copayment and/or Coinsurance amount from you at the time of purchase.

  Once the three-day supply has been used, you may return to the Pharmacy to obtain the remainder of your Prescription Order. The Participating Retail Pharmacy will resubmit the claim electronically to determine whether the Precertification request has been approved or denied.

  – If Precertification is approved for the drug, you may return to the Pharmacy to obtain the full Prescription Order, subject to any Deductible, Copayment and/or Coinsurance amount applicable to the balance of the drug quantity dispensed.

  – If the Precertification is denied, you may obtain the Prescription Order by paying the full cost for the drugs.

– Regardless of BlueLincs' decision, you will be notified in writing regarding the outcome of your Precertification approval request.

If you purchase your prescriptions from a nonparticipating pharmacy, or if you fail to present your ID card to a Participating Retail Pharmacy at the time of purchase, you will be responsible for paying the full cost of the Prescription Order. Benefits for Prescription Drugs are provided only when the Prescription Order is written ay a Participating Physician and dispensed by a Participating Retail Pharmacy, except in emergency situations as determined by BlueLincs.

If you present your Prescription Order to a Participating Retail Pharmacy and the electronic system is unavailable to determine the appropriate benefits, you should pay the Participating Retail Pharmacy for the Prescription Order. To receive reimbursement, you must submit a written request, along with the Participating Retail Pharmacy's itemized statement to:

BlueLincs HMO
Member Services Department
P. O. Box 21128
Tulsa, Oklahoma 74121-1128

To view a listing of the drugs which are included in the Precertification/ Step Therapy program, please visit our Web site at www.bcbsok.com. If you have questions about Step Therapy, or any other aspects of the Precertification process, please call 1-800-580-6202 for assistance.

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Except as amended, your Member Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR HANDBOOK FOR FUTURE REFERENCE.

RIDER REGARDING EXCLUSIONS

Your Member Handbook and Schedule(s) of Benefits are amended as set forth below:

- The "***Human Organ, Tissue and Bone Marrow Transplant Services***" section is amended so that the exclusion for "tandem transplants" is deleted and replaced by the following exclusion:

  Tandem transplants for autologous or allogeneic Bone Marrow or stem cell or progenitor cell treatment or rescue, with or without High-Dose Chemotherapy and/or High-Dose Radiation Therapy, except for a tandem transplant for autologous Bone Marrow or stem cell or progenitor cell treatment or rescue with High-Dose Chemotherapy to treat newly diagnosed or responsive multiple myeloma, only.

- The "***Schedule of Benefits***" is amended as follows:

  – Any benefit provisions or exclusions specifying that an accident must have occurred on or after your Effective Date shall no longer apply.

  – The exclusion for "evaluation and treatment of mental retardation (except for medical treatment) or evaluation and treatment of learning disabilities, including attention deficit disorder and behavioral and conduct disorder" is amended by the addition of the following provision:

    This exclusion shall not apply to the following Medically Necessary services:

    ○ Physicians' services (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Members age 19 and under; or

    ○ Prescription Drug therapy (provided your coverage includes supplemental benefits for Prescription Drugs) for treatment of ADD/ADHD in Members age 19 and under.

- The following exclusions are hereby added:
  - Telephone, email or other electronic consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
  - Family or marital counseling.
  - Hippotherapy, equine assisted learning, or other therapeutic riding programs.

- In the event your coverage includes a supplemental ***Schedule of Benefits for Prescription Drugs***, the exclusion for "drugs used for treatment of learning disabilities, including Attention Deficit Disorder and behavioral and conduct disorders" is amended so that this exclusion shall not apply to Prescription Drug therapy for treatment of ADD/ADHD in Members age 19 and under, subject to BlueLincs' guidelines for Precertification.

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Except as amended, your Member Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR MEMBER HANDBOOK FOR FUTURE REFERENCE.

RIDER REGARDING
INDIVIDUAL CONVERSION COVERAGE

Effective January 1, 2005 (or your Effective Date, if later), your Member Handbook is amended so that the section entitled, "**Conversion Privilege After Termination of Group Coverage**," is hereby deleted and replaced by the following provisions:

Conversion Privilege After Termination of Group Coverage

If you stop being a Member under the Agreement or you change jobs and your new employer does not offer group health insurance, and if you continue to reside or work in the BlueLincs Service Area, you may apply for conversion coverage by following these procedures:

- Contact the BlueLincs Enrollment Department at 918-560-2387 to request conversion information and an application form.
- Complete the application and **send it directly to BlueLincs within 31 days of the date your Group coverage ended.**

Your coverage will become effective the day after your Group coverage terminates if the appropriate premium is paid and the procedures mentioned above are followed.

A conversion contract will not be available if you no longer live or work within the BlueLincs Service Area, or if your coverage is terminated due to:

- non-payment of premium by your Employer;
- termination by BlueLincs;
- non-payment of required Copayments and/or Deductibles;
- commission of fraud or misrepresentation; or
- termination of the Agreement.

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Except as amended, your Member Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR MEMBER HANDBOOK FOR FUTURE REFERENCE.

BlueLincs
Blue Cross and Blue Shield of Oklahoma
BlueLincs HMO is a Wholly Owned Subsidiary of Blue Cross and Blue Shield of Oklahoma,
a Member of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans.
1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

NO SURPRISES ACT AMENDMENT

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

The terms of this Amendment supersede the terms of the Member Handbook to which this Amendment is attached and becomes a part of the Member Handbook. Unless otherwise required by Federal or Oklahoma law, in the event of a conflict between the terms on this Amendment and the terms of the Member Handbook, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to you and your mean any Member, including Subscriber and Dependents.

The Member Handbook is hereby amended as indicated below:

I. PCP Selection

The Plan requires the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members.

Until you make this designation, BlueLincs designates one for You. For information on how to select a PCP and for a list of the participating PCPs, contact BlueLincs at www.bcbsok.com or customer service at the toll-free number on the back of your Identification Card.

For Dependent children, you may designate any Participating Provider who specializes in pediatric care as their Primary Care Physician (PCP).

II. OB/GYN Care

You are not required to obtain a referral or authorization from Your Primary Care Physician (PCP) or Women's Principal Health Care Provider (WPHCP) before obtaining Covered Services from any Participating Provider specializing in obstetrics or gynecology. However, before obtaining Covered obstetrical or gynecological care, the Provider must comply with certain policies and procedures required by Your Plan, including Prior Authorization and referral policies. For a list of Participating Providers who specialize in obstetrics or gynecology, visit www.bcbsok.com or contact customer service at the toll-free number on the back of Your identification card.

III. Continuity of Care

If You are under the care of a Participating Provider as defined in the Member Handbook who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are

currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Member Handbook.

IV. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Member Handbook and this Amendment, those terms will apply only to their use in the Member Handbook or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- Covered Services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSOK for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with [Health Plan] for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSOK setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to

which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSOK setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your Participating Provider Deductible and/or Out-of-Pocket Limit, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If you receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill you is your in-network cost-share. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is Your Plan's in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at Participating Facilities, Non-Participating Providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for Plan Years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

BlueLincs HMO

Chief Executive Officer

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

A. AMENDMENT RESPECTING COVERED INSULIN DRUG COST SHARE

1. The ***Prescription Drug Schedule of Benefits*** and the ***Prescription Drug Benefit*** sections are hereby amended to add the following note:

   Note: The amount you may pay for a covered insulin drug shall not exceed $30 per 30-day supply or $90 per 90-day supply.

2. The *"If you need drugs to treat your illness or condition" provision* of the ***Summary of Benefits and Coverage (SBC)*** section is hereby amended with the addition of the following:

   Your cost for a covered insulin drug will not exceed $30 per 30-day supply or $90 per 90-day supply.

B. AMENDMENT RESPECTING VIRTUAL VISITS

1. The ***Schedule of Benefits*** is hereby amended with the addition of the following footnote, where applicable:

   Cost shares for Covered Services provided through Virtual Visits will be the same as if provided in-person, except where otherwise noted.

2. The "*Types of Covered Care" provision of the **How BlueLincs Works** section* is hereby amended by the addition of the new "Virtual Visits" provision below:

   VIRTUAL VISITS

   This plan provides Benefits for Medically Necessary Virtual Visits. Virtual Visits provide access to Providers in situations that may be appropriately handled using technology without a traditional in-person visit. Cost-sharing amounts for Covered Services provided through a Virtual Visit are usually the same as, and will not exceed, the cost share that would apply if those Covered Services were provided through a traditional in-person visit.

   Note: To be covered under the Virtual Visits benefit, a Covered Service must be appropriately provided through telemedicine. Virtual Visit benefits may be limited consistent with the coding and clinical standards recognized by the American Medical Association or the Centers for Medicare and Medicaid Services.

3. The Definitions section is hereby amended with the addition of the following "Virtual Visits" definition:

   VIRTUAL VISITS

   Covered Services appropriately delivered by a licensed Provider using technology-enabled health and care management and delivery systems that extend capacity and access as allowed by applicable law. Also known as telehealth or telemedicine.

4. The exclusion for "Telephone, email or other electronic consultations" in the ***Exclusions and Limitations*** section is hereby deleted and replaced by the following:

   - Missed appointments or completion of a claim form.

C. AMENDMENT RESPECTING COST SHARE REQUIREMENTS FOR PRESCRIPTION DRUGS

1. The ***Prescription Drug Schedule of Benefits*** is hereby amended with the addition of the following language:

   Any amounts paid by you, or on your behalf, for a Covered Drug will be used to calculate your cost-sharing requirements.

2. Any language indicating amounts paid by you, or on your behalf, for Covered Drugs will not be included when calculating your cost-sharing requirements, including any Copayment, Coinsurance, Deductible or Out-of-Pocket Limit, is hereby deleted in its entirety.

D. AMENDMENT RESPECTING BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

1. If your Plan includes the ***Vision Care Benefits Member Handbook***, the "*Benefit Determinations for Properly Filed Claims"* provision is hereby deleted in its entirety and replaced with the following:

   BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

   Once BlueLincs receives a completed claim form from you or your Provider, a Benefit determination will be made in accordance with applicable state and federal law.

   Upon receipt of your claim, if BlueLincs determines that additional information is necessary in order for your claim to be a Properly Filed Claim, we will provide written notice to you and/or your Provider, in accordance with state and federal law, requesting the specific information needed.

   The procedure for appealing an Adverse Benefit Determination is set forth below.

2. The *"Benefit Determinations for Properly Filed Claims"* provision of the ***Methods of Payment and Claim Filing*** section is hereby deleted in its entirety and replaced with the following:

   BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

   Once BlueLincs receives a Properly Filed Claim from you or your Provider, a Benefit determination will be made in accordance with applicable state and federal law.

   Upon receipt of your claim, if BlueLincs determines that additional information is necessary in order for your claim to be a Properly Filed Claim, we will provide written notice to you and/or your Provider, in accordance with state and federal law, requesting the specific information needed.

   In some instances, your Medical Group may be receiving the claim and making the Benefit determinations on behalf of BlueLincs.

   The procedure for appealing an Adverse Benefit Determination, whether made by BlueLincs or your Medical Group, is set forth in the section entitled ***Member Complaints and Appeals***.

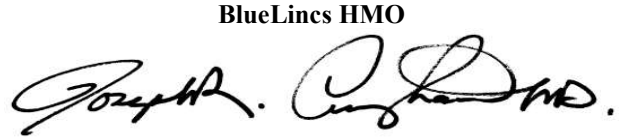
3. The footnote for the "Pre-Service Claims" table and the "Post-Service Claims" table in the ***Member Complaints and Appeals*** section are hereby deleted.

The above changes to your Group Health Plan are effective on the first renewal date following November 1, 2021.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

BlueLincs HMO



Chief Executive Officer

Blue Cross and Blue Shield of Oklahoma

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

A. AMENDMENT RESPECTING PREAUTHORIZATION

Preauthorization is updated throughout the Member Handbook as discussed below:

1. Wherever the term "Preauthorization/Precertification" appears in the Member Handbook is hereby deleted and replaced with "Prior Authorization".
2. The section entitled ***Preauthorization/Precertification*** is hereby renamed as ***Utilization Management.***
3. The ***Utilization Management*** section is hereby amended as follows:

   - The following provision entitled *"Utilization Management"* is hereby added:

     UTILIZATION MANAGEMENT

     Utilization management may be referred to as Medical Necessity reviews, utilization review (UR), or medical management reviews. Medical Necessity reviews will occur when a Provider requests a Prior Authorization before services are rendered. However, some services may require a Post-Service Medical Necessity Review if indicated by a medical policy.

     Types of Utilization Management

     - Prior Authorization Reviews
     - Predetermination Reviews; and
     - Post-Service Medical Necessity Reviews.

     Refer to the definition of Medically Necessary under the ***Definitions*** section of this Plan for additional information regarding any limitations and/or special conditions pertaining to your Benefits.

     Prior Authorization is the process of requiring Participating Providers or Medical Group Participating Providers to obtain authorization from a Member's Primary Care Provider and/or BlueLincs prior to scheduling all non-primary care Medical Services (excluding Emergency Care). Failure to follow this process will result in denial of Benefits. The Prior Authorization process may be handled by BlueLincs, your PCP and/or your Medical Group. In any event, the process for obtaining Prior Authorization is as follows:

   - The following provision entitled *"Preauthorization Requests Involving Non-Urgent Care*" is hereby deleted and replaced with the following:

     PRIOR AUTHORIZATION REQUESTS INVOLVING NON-URGENT CARE

     Except in the case of a Request Involving Urgent Care (see below), you will be provided with a written response to your request no later than five business days following the date we receive your request. This period may be extended one time for up to 15 additional days, if it is determined that additional time is necessary due to the nature or complexity of the request.

     If an extension of time is necessary due to the need for additional information, you will be notified of the specific information needed, and you will have 45 days from receipt of the notice to provide the additional

information. If information or documents are needed from a Participating Provider, BlueLincs will request the information from the Provider. BlueLincs will provide a written response to your request for Prior Authorization within five days following receipt of the additional information.

The procedure for appealing an adverse Prior Authorization determination is set forth in the section entitled ***Member Complaints and Appeals***.

- The following provision entitled *"Preauthorization Requests Involving Urgent Care*" is hereby deleted and replaced with the following:

PRIOR AUTHORIZATION REQUESTS INVOLVING URGENT CARE

A *"Prior Authorization Request Involving Urgent Care"* is any request for Medical Care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations:

- could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or
- in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Prior Authorization request.

In case of a *"Prior Authorization Request Involving Urgent Care"*, BlueLincs will respond to you no later than 72 hours after receipt of the request, unless you fail to provide sufficient information, in which case, you will be notified of the missing information within 24 hours and will have no less than 48 hours to provide the information. A benefit determination will be made as soon as possible (taking into account medical exigencies) but no later than 72 hours after the initial request, or within 48 hours after the missing information is received (if the initial request is incomplete).

- The following provision entitled *Predetermination Review* is hereby added:

PREDETERMINATION REVIEW

Predetermination is an optional Medical Necessity review by BlueLincs of a medical procedure, treatment or test, that has been recommended by your Physician in order to determine if it meets approved BlueLincs medical policy guidelines. A Predetermination review is not the same as Prior Authorization. Prior Authorization is a required process for the Provider to get approval from the Plan before you are admitted to the hospital for certain types of Covered Services. A Predetermination review can help you avoid unexpected out-of-pocket costs by determining ahead of time if a recommended service will be covered by your health care plan. If a service requires Prior Authorization, a Predetermination is not available.

Predetermination review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Plan. Please coordinate with your Provider to submit a request for Predetermination.

Below are some examples (not an exhaustive list) of common services for which a Predetermination review is recommended:

- Certain higher cost durable medical equipment;
- Surgeries that might be considered cosmetic; and
- Services and supplies that may be Experimental/Investigational under certain circumstances

General Provisions Applicable to All Predeterminations

1. No Guarantee of Payment

A Predetermination is not a guarantee of Benefits or payment of Benefits by the Plan. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Even if the service has been approved on Predetermination, coverage or payment can be affected for a variety of reasons. For example, the Member may have become ineligible as of the date of service or the Member's Benefits may have changed as of the date of service.

2. Request for Additional Information

The Predetermination process may require additional documentation from the Member's health care Provider or pharmacist. In addition to the written request for Predetermination, the health care Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

- The following provision entitled *Post-Service Medical Necessity Review* is hereby added:

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review is only available when a claim is filed, and medical policy requires a Medical Necessity review. Post-Service Medical Necessity reviews are not available for any other services.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. No Guarantee of Payment

A Post-Service Medical Necessity Review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Post-Service Review does not guarantee payment of Benefits by the Plan, for instance a Member may become ineligible as of the date of service or the Member's Benefits may have changed as of the date of service.

2. Request for Additional Information

The Post-Service Medical Necessity Review process may require additional documentation from the Member's health care Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

4. The ***Definitions*** section is updated as follows:

- The following definition for "Post-Service Medical Necessity Review" has been added:

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

- The "Preauthorization" definition has been deleted.
- The "Predetermination" definition below has been added:

PREDETERMINATION

An optional voluntary review of a Provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to make sure it meets approved BlueLincs medical policy guidelines and Medical Necessity requirements.

- The following definition for "Prior Authorization" below has been added:

PRIOR AUTHORIZATION

The process of requiring Participating Providers or Medical Group Participating Providers to obtain authorization from a Member's Primary Care Provider and/or BlueLincs prior to scheduling all non-primary care Medical Services (excluding Emergency Care).

B. AMENDMENT RESPECTING PRIMARY CARE PHYSICIAN (PCP)

1. Wherever the term "Primary Care Physician" appears in the Member Handbook is hereby deleted and replaced with "Primary Care Provider".
2. The ***Definitions*** section is updated as follows:
   - The definition for "Primary Care Physician (PCP)" has been deleted.
   - The following definition for "Primary Care Provider (PCP)" has been added:

     A person who is a professional practitioner of a Healing Art defined and recognized by law, to include family practitioner, obstetrician/gynecologist, pediatrician, behavioral health practitioner, internist and physician assistant or advanced practice nurse who provides health care and services generally accepted within the scope of the Provider's license. A PCP is not a Specialist.

C. **AMENDMENT RESPECTING MENTAL ILLNESS**

1. Wherever the term "Mental Illness" appears in the Member Handbook is hereby deleted and replaced with "Mental Health and Substance Use Disorder".
2. The ***Definitions*** section is amended so that the title of the definition "Mental Illness" is hereby deleted and replaced by the title "Mental Health and Substance Use Disorder".

D. AMENDMENT RESPECTING CLINICAL LANGUAGE

The ***How BlueLincs Works*** section is hereby amended to include the following:

Certain services are covered pursuant to BlueLincs' medical policies and clinical procedure and coding policies, which are updated throughout the plan year. The medical policies are guides considered by BlueLincs when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational/Unproven, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the Plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsok.com or by contacting a Customer Service Representative at the number shown on your Identification Card.

E. AMENDMENT RESPECTING THERAPEUTIC EQUIVALENT RESTRICTIONS

The "*Therapeutic Equivalent Restrictions"* provision of the ***Outpatient Prescription Drug Benefits*** section is hereby deleted and replaced with the following:

Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, BlueLincs may limit benefits to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your Benefit, the drug purchased will not be covered under any Benefit level.

F. AMENDMENT RESPECTING EXCLUSIONS AND LIMITATIONS

The ***Exclusions and Limitations*** section set forth is amended as follows:

1. The exclusion for "Unspecified developmental disorders" is hereby deleted and replaced with the following:

   For unspecified developmental disorders that are not related to a specified medical condition, except as described in the "*Services Related to Treatment of Autism Spectrum Disorder"*.
2. The following exclusion is hereby added:

   For or related to Applied Behavior Analysis, except for the treatment of Autism Spectrum Disorder as described under *"Services Related to Treatment of Autism Spectrum Disorder"*.

The above changes to your Group Health Plan are effective on the first renewal date following April 1, 2022.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

BlueLincs HMO

Chief Executive Officer

BlueLincs
Blue Cross and Blue Shield of Oklahoma
1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

A. AMENDMENT RESPECTING THE GROUP MASTER AGREEMENT

The term "Group Master Agreement" is hereby amended as follows:

- The term "Group Master Agreement", wherever used in the Member Handbook, is hereby deleted and replaced with "Group Administration Document".
- The Definition for "Agreement" is hereby deleted and replaced with the following:

  The Group Administration Document issued to the Employer by BlueLincs. This Member Handbook contains the principal provisions of the Group Administration Document, ***Schedule of Benefits*** and any attachments and/or riders.

B. AMENDMENT RESPECTING OUT-OF-POCKET MAXIMUM

The term "Out-of-Pocket Maximum", wherever used in the Member Handbook, is hereby deleted and replaced with "Out of Pocket Limit".

C. AMENDMENT RESPECTING EXCLUSIONS

The Exclusions and Limitations section set forth in the ***Schedule of Benefits*** is amended as follows:

- The exclusion for "refractions" is hereby deleted and replaced with the following:
  - Refractions, including lens prescriptions, corrective eyeglasses and frames or contact lenses (including the fitting of the lenses), or toric or accommodating intraocular lens implants except as may be specifically provided for in the ***Schedule of Benefits***. Refractive surgery is excluded.
- The exclusion for orthognathic surgery is hereby deleted and replaced with the following:
  - Orthognathic Surgery, osteotomy or any other form of oral Surgery, dentistry or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:
    - the treatment of accidental injury to the jaw, sound natural teeth, mouth or face;
    - the improvement of the physiological functioning of a malformed body member resulting from a congenital defect, including cleft lip and cleft palate;
    - dental extractions performed in preparation for radiation treatment for neoplasms involving the jaw/mouth; or
    - dental extractions of diseased teeth prior to a solid organ transplant.
  - Dental implants or associated procedure or for any complications arising from such procedures.

- The exclusion for "Continuous Passive Motion (CPM) devices" is deleted and replaced by the following:
  - Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for certain knee procedures determined to be Medically Necessary per our medical policy.

D. AMENDMENT RESPECTING THE OKLAHOMA INSURANCE DEPARTMENT'S ADDRESS

The Oklahoma Insurance Department's address, wherever used in the Member Handbook and Notices, is hereby updated to the address below:

Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105

The above changes to your Group Health Plan are effective on the first renewal date following January 1, 2021.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

BlueLincs HMO

Chief Executive Officer

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AMENDMENTS RESPECTING OUTPATIENT PRESCRIPTION DRUGS

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

The ***Outpatient Prescription Drug Benefits*** section or ***Outpatient Prescription Drugs and Related Services*** section of your Member Handbook is amended as set forth below:

A. ORAL CHEMOTHERAPY

The benefits regarding Oral Chemotherapy are hereby deleted and replaced with the following:

- Oral Chemotherapy when prescribed by a licensed Physician. Your Copayment, Coinsurance and/or Deductible amount will not apply to orally administered anticancer medications when received from a Participating Pharmacy. Coverage of prescribed orally administered anticancer medications will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

B. BENEFITS

The benefits of this section are amended as set forth below:

- The following provision clarifying Prescription Drugs has been added:
  - Prescription Drugs dispensed for a Member's Outpatient use, when recommended by and while under the care of a Physician or other Provider.
- The provision regarding "insulin and insulin products" is hereby deleted and replaced with the following:
  - Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician or other Provider even though a prescription may not be required by law.

C. PRESCRIPTION DRUG SUPPLY/DISPENSING LIMITS

The Prescription Drug Supply/Dispensing Limits subsection is amended by the addition of the following:

- **Controlled Substances Limitation**

  If BlueLincs determines that a Member may be receiving quantities of controlled substance medications not supported by FDA-approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to a review for Medical Necessity, appropriateness and other coverage restrictions which may include but not limited to limiting coverage to services provided by a certain Provider and/or Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. Additional Copayment and/or Coinsurance may apply. For the purposes of this provision, controlled substance medications are medications classified and restricted by state or federal laws.

D. BRAND NAME EXCLUSION

The provision regarding "Brand Name Exclusion" is hereby deleted and replaced with the following:

THERAPEUTIC EQUIVALENT RESTRICTIONS

Some therapeutic equivalent drugs are manufactured under multiple names. In some cases, Benefits may be limited to only one of the therapeutic equivalents available. If you do not choose the therapeutic equivalents that are covered under this Benefit section, the drug purchased will not be covered under any Benefit level.

E. DEFINITIONS

The ***Definitions*** section of the Member Handbook is amended so that the definition of "Prescription Drug" is hereby deleted and replaced by the following:

Prescription Drug

Any medicinal substance required by the Federal Food, Drug and Cosmetic Act to bear the following legend on its label: "Caution: Federal Law prohibits dispensing without prescription."

F. THE PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

The ***General Provisions*** section of the Member Handbook is amended so that the maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 5.5% of the total sales for all rebatable products of such manufacturer dispensed during any given Calendar Year to members of BlueLincs and other Blue Plan operating divisions.

The above changes to your Group Health Plan are effective on the first renewal date following January 1, 2021.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

BlueLincs HMO

Chief Executive Officer

Blue Cross and Blue Shield of Oklahoma

BlueLincs HMO is a Wholly Owned Subsidiary of Blue Cross and Blue Shield of Oklahoma,
a Member of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans.

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

A. The ***Schedule of Benefits for Covered Health Care Services*** is amended as follows:

- Benefits for the treatment of Mental Illness Services, including treatment of alcohol and drug abuse, shall be equal to the Benefits provided under the Member Handbook for the treatment of all other physical diseases and disorders, subject to the same provisions regarding:
  - Deductible, Copayment (if applicable) and/or Coinsurance provisions; and
  - Preauthorization and utilization review mechanisms.
  - The "Office Visit Copayment" (if applicable) shall be applied to Mental Illness Services on the same basis as such Copayment provisions are applied to office visits related to treatment of any other medical condition.
  - Covered Mental Illness Services shall be paid at the same Benefit percentage rate applicable to other covered Hospital Services and surgical/medical services.
  - Covered Mental Illness Services shall count toward the Out-of-Pocket Limit applicable to all other Covered Services.
  - The Inpatient stay limits and Outpatient visit limits specified in your Member Handbook for treatment of Mental Illness Services shall no longer be applicable.

B. The terms "substance abuse" and "substance abuse disorders", wherever used in the Member Handbook are hereby deleted.

C. The ***Definitions*** section is amended so that the definition of "Mental Illness" is hereby deleted and replaced by the following:

Any condition or disorder involving a mental health condition or substance use disorder listed under any of the diagnostic categories in the mental disorders section of the most recent edition of the International Classification of Disease or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

The above changes to your Group Health Plan are effective on the first of the following dates occurring on or after November 1, 2020 of the Group's first Agreement Date Anniversary (renewal date).

BlueLincs HMO

Chief Executive Officer

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

A. **AMENDMENT RESPECTING URGENT CARE – WITHIN THE STATE OF OKLAHOMA**

The provision outlining Urgent Care within the State of Oklahoma is hereby deleted and restated as follows:

Urgent Care is defined as treatment for an unexpected illness or injury that is not an emergency, but which severe or painful enough to require treatment within 24 hours. Examples include, but are not necessarily limited to: lacerations, high fever, vomiting and diarrhea, pulled muscles, or other similar illnesses or injuries.

If you need Urgent Care, place a call to your PCP to explain the illness or injury. Your PCP may instruct you in a method of home care, ask you to come to the office or advise you to go to another facility. Use of an Urgent Care center or emergency room for Urgent Care that is not Preauthorized by your PCP is not covered. All follow-up care must be provided or prearranged through your PCP.

B. **AMENDMENT RESPECTING CONTROLLED SUBSTANCES LIMITATIONS**

The provision outlining controlled substances is hereby deleted and restates as follows:

If BlueLincs determines that a Member may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, Benefits may be subject to a review to determine Medical Necessity, or appropriateness and other restrictions may include but not be limited to a certain Provider and/or Participating Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. Additional Copayments may apply. For the purposes of this provision, controlled substance medications are medications classified and restricted by state or federal laws.

C. **AMENDMENT RESPECTING EXCLUSIONS AND LIMITATIONS**

The 'Exclusions and Limitations' as outlined in ***Outpatient Prescription Drugs and Related Services*** is hereby amended by the addition of the following exclusion:

- Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

D. **AMENDMENT RESPECTING EXCLUSIONS**

The ***Exclusions*** section is hereby amended so that the exclusion for 'Inpatient treatment for any non-covered dental procedure' is hereby deleted and restated as follows:

- Services, supplies or charges related to Inpatient treatment for any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services and anesthesia services associated with any Medically Necessary dental procedure when provided to a Member who is; severely disabled; or who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or who, in the judgment of the treating practitioner, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.

The above changes to your Group Health Plan are effective on the first renewal date following October 15, 2019.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

BlueLincs HMO

Chief Executive Officer

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

A. **AMENDMENT RESPECTING PREVENTIVE CARE SERVICES**

The 'Preventive Care Services' provisions outlined in the ***Special Benefit Provisions*** section are amended by the addition of the following:

Preventive Care Services will be implemented in the quantities and within the time periods allowed under applicable law.

B. **AMENDMENT RESPECTING EMERGENCY CARE**

The ***Types of Covered Care*** and ***Definitions*** sections are amended so that the provision/definition for "Emergency Care" is hereby deleted and replaced by the following:

EMERGENCY CARE

BlueLincs defines Emergency Care as treatment in a Hospital emergency department (emergency room) or other comparable facility for any injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

- serious jeopardy to the Member's health (or, with respect to a pregnant woman, the health of the woman or her unborn child);
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions:
  - there is inadequate time to effect a safe transfer to another hospital before delivery, or
  - transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples include, but are not necessarily limited to: major trauma, loss of consciousness, suspected heart attacks, severe abdominal or chest pains, fractures, uncontrolled bleeding, burns, attempted suicide or poisonings.

C. **AMENDMENT RESPECTING NON-PARTICIPATING PROVIDERS OUTSIDE THE BLUELINCS SERVICE AREA**

The provisions outlining 'Non-Participating Providers Outside the BlueLincs Service Area' of the ***General Provisions*** section are hereby deleted and replaced by the following:

- **Non-Participating Providers Outside the BlueLincs Service Area**
  - **Liability Calculation**

    In general, when Covered Services are provided outside of the BlueLincs' Service Area by non-participating Providers, the amount(s) a Member pays for such services will be calculated using the methodology described in the Agreement for non-participating Providers located inside our Service Area. You may be responsible for the difference between the amount that the non-participating Provider bills and the payment BlueLincs will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

  - **Exceptions**

    In some exception cases, BlueLincs may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not available, then BlueLincs may make a payment based on the lesser of:

    - the amount calculated using the methodology described in the Agreement for non-participating Providers located inside our service area (described above): or
    - the following:
      - for professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable; or
      - for Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

    In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment BlueLincs will make for the Covered Services as set forth above.

D. AMENDMENT RESPECTING BLUECARD WORLDWIDE NAME CHANGE TO BLUE CROSS BLUE SHIELD GLOBAL CORE

Wherever the name "BlueCard Worldwide" appears in the Member Handbook is hereby deleted and replaced with "Blue Cross Blue Shield Global Core".

E. AMENDMENT RESPECTING RIGHT OF RECOUPMENT

The ***General Provisions*** section is amended so that the provisions outlining 'Right of Recoupment' are hereby deleted and restated as follow:

RIGHT OF RECOUPMENT

You agree to reimburse BlueLincs for Benefits it has paid and for which you were not eligible under the terms of the Agreement. This payment is due and payable immediately upon notification by BlueLincs. Also, BlueLincs has the sole right to determine that any overpayments, wrong payments or any excess payments made under the Agreement are an indebtedness which may be recovered by BlueLincs by deducting it from any future Benefits to which you may be entitled under the Agreement, or under any other coverage provided to you by BlueLincs. BlueLincs' acceptance of premiums or payment of Benefits under the Agreement does not waive its rights to enforce these provisions in the future.

- **BlueLincs' Right of Recoupment for Overpayments**

  If BlueLincs pays Benefits for Covered Services incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error ("Overpayment"), BlueLincs has the right to obtain a refund of the Overpayment from: (i) the person to, or for whom, such Benefits were paid, or (ii) any

insurance company or plan, or (iii) any other persons, entities or organizations, including, but not limited to, Participating Providers or Out-of-Network Providers.

If no refund is received, BlueLincs (in its capacity as an insurer or administrator) has the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

– any future Benefit payment made to any person or entity under this Agreement, whether for the same or a different Member; or

– any future benefit payment made to any person or entity under another BlueLincs-administered group self-funded benefit program and/or BlueLincs-administered insured benefit program or policy; or

– any future benefit payment made to any person or entity under another BlueLincs-insured group benefit plan or individual policy; or

– any future benefit payment, or other payment, made to any person or entity; or

– any future payment owed to one or more Participating Providers or Out-of-Network Providers.

Further, BlueLincs has the right to reduce your benefit plan's or policy's payment to a Provider by the amount necessary to recover another BlueLincs' plan's or policy's Overpayment to the same Provider and to remit the recovered amount to the other BlueLincs plan or policy.

This right of recovery is limited to 24 months after the payment is made, unless:

– the payment was made because of fraud committed by you or your Provider;

– you or your Provider has otherwise agreed to make a refund to BlueLincs for overpayment of the claim.

- **BlueLincs' Right of Recoupment for Third Party Proceeds**

  To the extent BlueLincs provides or pays Benefits for Covered Services for any injury, illness or condition which occurs through the omission or commission of any act by another person, you agree that BlueLincs shall have a first lien on any settlement proceeds, and you shall reimburse and pay BlueLincs, on a first-priority basis, from any money recovered by suit, settlement, judgment or otherwise from any third party or his or her insurer or from any carrier providing uninsured/underinsured motorist coverage. You shall reimburse BlueLincs on a first-priority basis regardless of whether a lawsuit is actually filed or not and, if settled, regardless of how the settlement is structured or which items of damages are included in the settlement, and regardless of whether or not he or she is made whole or is fully compensated for any injuries.

  You are required to hold in trust for BlueLincs any money (up to the amount of benefits paid by BlueLincs) recovered as described above. You are required to cooperate and furnish information and assistance which BlueLincs may require to obtain this reimbursement, including signing legal documents.

  BlueLincs HMO expressly disclaims all make whole and common fund rules and doctrines and any other rule or doctrine that would impair or interfere with BlueLincs HMO's rights herein.

F. **AMENDMENT RESPECTING DEFINITIONS**

The ***Definitions*** section is amended so the following definitions are hereby deleted and replaced as stated.

– **EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN**

A drug, device, biological product, or medical treatment or procedure is Experimental, Investigational or Unproven if **BlueLincs determines** that:

- The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or

- The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or

its efficacy as compared with the standard means of treatment or diagnosis; or

- The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Approval by a governmental or regulatory agency will be taken into consideration by the Plan in assessing Experimental/Investigational/Unproven status of a drug, device, biological product, or medical treatment or procedure but will not be determinative.

– **TOTAL DISABILITY (OR TOTALLY DISABLED)**

A condition resulting from disease or injury in which, as certified by a Physician:

- A Member is unable to perform the substantial duties of any occupation or business for which he/she is qualified and the Member is not in fact engaged in any occupation for wages or profit; or
- If the Member does not usually work for wages or profit, the Member cannot do the normal activities of a similarly situated person who is not disabled.

BlueLincs reserves the right to review a Physician's certificate of disability and/or request medical records and/or require a medical examination by an independent Physician to verify disability at the Member's expense. BlueLincs will make the final determination as to whether the Member is Totally Disabled.

The above changes to your Group Health Plan are effective on the first renewal date following February 1, 2018.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

BlueLincs HMO

Chief Executive Officer

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENT RESPECTING OUTPATIENT PRESCRIPTION DRUGS

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

The ***Outpatient Prescription Drug Benefits*** section or ***Outpatient Prescription Drug and Related Services*** section of your Member Handbook is amended as follows.

A. **PRESCRIPTION DRUG SUPPLY/DISPENSING LIMITS**

The provisions of this section are amended so that the Controlled Substance Limitation provision is hereby deleted and restated as follows:

Controlled Substances Limitation

If BlueLincs determines that a Member may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety treatment guidelines, Benefits may be subject to a review to determine Medical Necessity, appropriateness and other restrictions such as limiting coverage to services provided by a certain Provider and/or Participating Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. For the purposes of this provision, controlled substance medications are medications classified and restricted by state or federal laws.

B. The provision outlining Therapeutic Equivalent Restrictions is hereby deleted and restated as follows:

THERAPEUTIC EQUIVALENT RESTRICTIONS

Some drugs are manufactured under multiple names and have many therapeutic equivalents. In such cases, BlueLincs may limit Benefit to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under your Prescription Drug program, the drug purchased will not be covered under any Benefit level.

C. The Exclusions and Limitations outlined in this section are amended as follows:

- The following exclusions are hereby added:
  - Non-FDA approved drugs.
  - Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary) including, but not limited to, preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying and suspending agents.
  - Any self-administered drugs dispensed by a Physician.
- The following exclusions are hereby deleted and restated as follows:
  - Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances or similar devices (**except** lancets, test strips, and disposable hypodermic needles and syringes for self-administered injections). However, coverage for prescription contraceptive devices is provided under the medical benefits provisions of your Member Handbook.
  - Diagnostic agents, except diabetic testing supplies or test strips.

The above changes to your Group Health Plan are effective on the first of the following dates occurring on or after February 1, 2018:

1. **the Agreement Effective Date;**
2. **the Group's first Agreement Date Anniversary (renewal date); or**
3. **the first Plan Year of the Group Health Plan.**

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

BlueLincs HMO

Chief Executive Officer

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

A. **AMENDMENT RESPECTING BREAST-FEEDING SUPPORT, SERVICES AND SUPPLIES**

Benefits for electric breast pumps are limited to a maximum of one per Benefit Period.

B. **AMENDMENT RESPECTING EMERGENCY CARE**

The ***Types of Covered Care*** and ***Definitions*** sections are amended so that the provision/definition of "Emergency Care" is hereby deleted and replaced by the following:

EMERGENCY CARE

BlueLincs defines Emergency Care as treatment for any injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

- serious jeopardy to the Member's health (or, with respect to a pregnant woman, the health of the woman or her unborn child);
- serious impairment to bodily function;
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions:
  - there is inadequate time to effect a safe transfer to another hospital before delivery, or
  - transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples include, but are not necessarily limited to: major trauma, loss of consciousness, suspected heart attacks, severe abdominal or chest pains, fractures, uncontrolled bleeding, burns, attempted suicide or poisonings.

C. **AMENDMENT RESPECTING AMBULANCE SERVICES**

The Member Handbook is amended so that the "Ambulance Services" provisions are hereby deleted and replaced by the following:

- Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
  - From your home to a Hospital;
  - From the scene of an accident or medical emergency to a Hospital;
  - Between Hospitals;
  - Between a Hospital and a Skilled Nursing Facility; or
  - From the Hospital to your home.

- Ambulance Services means local transportation to the closest facility appropriately equipped and staffed for treatment of the Member's condition. If none, you are covered for trips to the closest such facility outside your local area.
- Ambulance Services for non-Emergency care may be covered when, in addition to the above requirements, the Member's condition is such that any other form of transportation would be medically contraindicated.
- Air ambulance services are covered only when:
  - Air ambulance services are Medically Necessary; and
  - Terrain, distance, your physical condition or other circumstances require the use of air ambulance services rather than ground ambulance services.

D. **AMENDMENT RESPECTING EXCLUSIONS**

The ***Exclusions*** section set forth in the Member Handbook is amended as follows:

- The exclusion for "payments provided under Medicare or governmental units" is hereby deleted and replaced by the following:
  - Any condition to the extent benefits would have been provided under Medicare, or to the extent governmental units provide benefits or would have provided benefits if you had applied for and claimed those benefits (some state or federal laws may affect how this exclusion is applied).
- The following exclusion is hereby added:
  - For transportation services, except as described under "Ambulance Services" in the ***Special Benefit Provisions*** section of the Member Handbook.

E. **AMENDMENT RESPECTING GENERAL PROVISIONS**

The ***General Provisions*** section is amended as set forth below:

- The provisions under the heading "Out-of-Area Services" are amended by the addition of the following:

  In some cases, BlueLincs may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating health care Provider on an exception basis.

- The following provision is hereby added:

  IDENTITY THEFT PROTECTION SERVICES

  As a Member, BlueLincs makes available at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair to help protect your information. These identity theft protection services are currently provided by BlueLincs' designated outside vendor and acceptance or declination of these services is optional to you. Members who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbsok.com. Services may automatically end when the person is no longer an eligible Member. Services may change or be discontinued at any time with or without notice and BlueLincs does not guarantee that a particular vendor or service will be available at any given time.

The above changes to your Group Health Plan are effective on the first renewal date following January 1, 2017.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

BlueLincs HMO

Chief Executive Officer

Blue Cross and Blue Shield of Oklahoma

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENT RESPECTING OUTPATIENT PRESCRIPTION DRUG BENEFITS

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended so that the provision outlining Prescription Drug refills is hereby deleted and replaced by the following:

Benefits will not be provided for a prescription refill until 75% of the previous Prescription Order (or 70% for covered prescription eyedrops) has been used by the Member. An exception to this provision may be granted on at least one occasion per year to synchronize the Prescription Drug refills for certain covered maintenance medications so that they are refilled on the same schedule (for a given time period). When necessary to permit synchronization, we shall apply a prorated daily cost-sharing rate to any covered medication dispensed by a Participating Pharmacy.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

The provisions of this amendment are effective as follows:

This amendment is effective November 1, 2017.

BlueLincs HMO

Chief Executive Officer

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

A. **AMENDMENT RESPECTING SMOKING CESSATION**

The ***Special Benefits Provisions*** section is amended so that the 'Preventive Care Services' provision related to smoking cessation is hereby deleted and restated as follows:

Tobacco use counseling and interventions (including a screening for tobacco use, counseling, and FDA-approved tobacco cessation medications).

Tobacco cessation medications are covered under the ***Outpatient Prescription Drugs and Related Services*** section of your Member Handbook when prescribed by a BlueLincs Provider.

B. **AMENDMENT RESPECTING SERVICES RELATED TO CLINICAL TRIALS**

The Member Handbook is amended so that the *"Services Related to Clinical Trials"* provisions are hereby deleted and restated as follows:

SERVICES RELATED TO CLINICAL TRIALS

Subject to the ***Exclusions***, conditions and limitations of this Member Handbook (including the Copayment, Coinsurance and/or Deductible provisions set forth in the ***Schedule of Benefits for Covered Health Care Services***), Benefits will be provided for Routine Patient Costs when provided in connection with a phase I, phase II, phase III, or phase IV clinical trial, that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is one of the following:

- Any of the following federally funded or approved trials:
  - The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
  - The National Institutes of Health (NIH);
  - The Centers for Medicare and Medicaid Services;
  - The Agency for Healthcare Research and Quality;
  - A cooperative group or center of any of the previous entities;
  - The United States Food and Drug Administration;
  - The United States Department of Defense (DOD);
  - The United States Department of Veterans Affairs (VA);

- A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system; or
- An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

- A clinical trial conducted under an FDA investigational new drug application.
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Benefits may not be available under this section for services that are paid for by the research institution conducting the clinical trial.

For purposes of this provision, "Routine Patient Costs" generally include all items and services consistent with the coverage provided under this Member Handbook for an individual with a similar condition who is not enrolled in a clinical trial. However, costs associated with the following are *not* Covered Services:

- The investigational item, device or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

C. AMENDMENT RESPECTING EXCLUSIONS

The ***Exclusions*** section set forth in your Member Handbook is amended as follows:

- The exclusion for "sex transformation" is hereby restated and replaced by the following:
  - For gender reassignment surgery or any treatment leading to or in connection with gender reassignment surgery.
- The exclusion for "orthognathic surgery" is hereby deleted and replaced by the following:
  - Orthognathic Surgery, osteotomy of the mandible or maxillae, correction of malocclusion, correction of malpositions of the teeth, and items or services for care, treatment, filling, removal, replacement or artificial restoration of the alveolar processes, gums, jaws or associated structures except for:
    - the treatment of accidental injury to the jaw, sound natural teeth, mouth or face;
    - the improvement of the physiological functioning of a malformed body member resulting from a congenital defect, including cleft lip and cleft palate;
    - dental extractions performed in preparation for radiation treatment for neoplasms involving the jaw/mouth; or
    - dental extractions of diseased teeth prior to a solid organ transplant.

D. AMENDMENT RESPECTING OUT-OF-AREA SERVICE

The "BlueCard" provisions of your Member Handbook are hereby deleted and replaced by the following:

OUT-OF-AREA SERVICES

BlueLincs HMO has relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you obtain health care services outside of our Service Area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

Typically, when accessing care outside our Service Area, you will obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating Providers.

Our reimbursement practices in both instances are described below.

Please note: The BlueLincs HMO Service Area is smaller than the Blue Cross and Blue Shield of Oklahoma Service Area; the BlueCard Program applies only outside of the Blue Cross and Blue Shield of Oklahoma Service Area. BlueLincs covers only limited health care services received outside of the BlueLincs Service Area. As used in this section, "Out-of-Area Covered Services" include Emergency Care or Urgent Care obtained outside the geographic area we serve. Follow-up care following an emergency is also available, provided the services are preauthorized by BlueLincs. Any other services will not be eligible for benefits unless authorized by BlueLincs.

- **BlueCard® Program**

  Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, BlueLincs HMO will remain responsible for what we agreed to in the Agreement. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

  The BlueCard Program enables you to obtain Covered Services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating Provider will automatically file a claim for the services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment, Coinsurance and/or Deductible amount, as stated in your Member Handbook and the ***Schedule of Benefits***.

  Whenever you receive Covered Services outside our Service Area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat-dollar Copayment, is calculated based on the lower of:

  – The billed charges for your Covered Services; or

  – The negotiated price that the Host Blue makes available to us.

  Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

  Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied after a claim has already been paid.

  Federal or state laws may require a surcharge, tax or other fee that applies to insured Employer accounts. If applicable, BlueLincs will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

  - **Non-Participating Health Care Providers Outside the BlueLincs Service Area**

    – **Your Liability Calculation**

      When Covered Services are received from non-participating Providers, the amount you pay for such services will be calculated using the methodology described in the Group Agreement for non-participating Providers located inside our Service Area. In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment we will make for the Covered Services as set forth in your Member Handbook.

      If you need Emergency Care, BlueLincs will cover you at the highest level that federal regulations allow. You will have to pay for any charges that exceed the Allowable Charge as well as for any Deductibles, Coinsurance, Copayments, and amounts that exceed any Benefit maximums. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

    – **Exceptions**

      BlueLincs may pay claims from non-participating Providers for Covered Services based on the Provider's billed charges for Covered Services, such as in situations where you did not have reasonable

access to a participating Provider, as determined by BlueLincs in BlueLincs' sole and absolute discretion or by applicable state law. In any of these exception situations, you may be responsible for the difference between the amount that the non-participating Provider bills and the payment BlueLincs will make for the Covered Services as set forth in this paragraph.

- **BlueCard Worldwide® Program**

  If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you may be able to take advantage of the BlueCard Worldwide® Program when accessing Emergency Care Services and Urgent Care. The BlueCard Worldwide Program is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit claims yourself to obtain reimbursement for these services.

  If you need medical assistance services (including locating a doctor or Hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

  - **Emergency Care Services**

    This Agreement covers only limited health care services received outside of the United States. As used in this section, "Out-of-Area Covered Services" include Emergency Care and Urgent Care obtained outside the geographic area we serve. Follow-up care following an emergency is also available. Any other services will not be eligible for Benefits unless authorized by BlueLincs.

  - **Inpatient Services**

    In most cases, if you contact the BlueCard Worldwide Service Center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your Deductibles, Coinsurance and/or Copayments, etc. In such cases, the Hospital will submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services.

    You must contact BlueLincs to obtain Preauthorization for non-emergency Inpatient services.

  - **Outpatient Services**

    Physicians, Urgent Care centers and other Outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

  - **Submitting a BlueCard Worldwide Claim**

    When you pay for Covered Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the Provider's itemized bill(s) to the BlueCard Worldwide service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BlueLincs, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

NOTE: BlueLincs may postpone or waive application of your Copayment, Coinsurance and/or Deductible whenever it is necessary in order to obtain Provider discounts for Covered Services you receive outside the state of Oklahoma.

E. AMENDMENT RESPECTING COORDINATION OF BENEFITS

The ***General Provisions*** section is amended so that the provisions outlining "Coordination of Benefits" are deleted in their entirety and replaced by the following:

COORDINATION OF BENEFITS

When a Member or a Dependent has health coverage with more than one health plan, there will be times when the two health plans will need to coordinate benefit coverage to decide who is responsible for payment to Providers. This is called coordination of benefits (COB).

Please note that this section only applies if the Member or Dependent has health coverage under more than one plan.

Definitions

In addition to the definitions listed on the back of this Member Handbook, the following apply to this COB provision:

- "**Other Agreement**" means any arrangement providing health care benefits or services through:
  - Group, group-type, non-group, individual, blanket or franchise insurance coverage;
  - Blue Cross, Blue Shield, Health Maintenance Organization and other prepayment coverage;
  - Coverage under labor-management trusteed plans, union welfare plans, Employer organizations plans or employee benefit organizations plans;
  - Coverage toward the cost of which any Employer has contributed, or with respect to which any Employer has made payroll deductions;
  - Group or individual automobile insurance coverage; and
  - Coverage under any tax supported or government program, including Medicare, to the extent permitted by law.

  Coverage under specific benefit arrangements, such as dental care or vision care benefit plans that are not part of a comprehensive health care benefit plan, shall be excluded from the definition of "Other Agreement" herein.
- **"Covered Service"** additionally means a service or supply furnished by a Hospital, Physician or other Provider for which benefits are provided under at least one Other Agreement covering the person for whom the claim is made or service provided.
- **"Dependent"** additionally means a person who qualifies as a Dependent under an Other Agreement.
- **"Primary Plan"** means the coverage that pays benefits or provides services first under the Order of Benefit Determination Rules below.
- **"Secondary Plan"** means any other coverage that is not a Primary Plan.

All Benefits provided under the Agreement are subject to this COB provision.

It is the responsibility of each Member to advise BlueLincs of his or her participation in any Other Agreement. We will occasionally request information from you regarding duplicate health coverage. This information is also requested on the BlueLincs application. Please complete and return the requested information promptly to ensure timely processing of your claims.

BlueLincs follows the COB rules established by state law, including the rules for determining the order in which Benefits are to be paid on behalf of Dependent children. Therefore, our Members do not have the option of choosing which plan they wish to have pay benefits first.

All Covered Services (except where Medicare is primary) must be preauthorized or precertified by your PCP and/or BlueLincs in accordance with the provisions of this Member Handbook and any Schedule(s) of Benefits.

Medicare

When Medicare is the primary payer, you may seek services from any Participating Medicare Provider.

Your Plan provides primary coverage for the following covered Medicare-eligible individuals:

- Active Employees and their spouses**, unless coverage is through an Employer with 20 Employees or less**;
- Members who are on renal dialysis for 30 months or less; and
- Members who are under 65 and who are eligible for Medicare by reason of disability.

For all other Medicare beneficiaries, Medicare is the primary carrier.

While primary medical coverage is being provided under this Plan, you may wish to enroll in Medicare, as expenses not reimbursed under this Plan may be reimbursed under Medicare. Be sure to apply for Medicare Part A (Hospital Insurance) and Part B (supplemental medical insurance) at least three months before your 65th birthday.

When Medicare provides primary coverage, this Plan will reduce Benefits payable for Covered Services by any benefits payable for the same Covered Services under Medicare.

When BlueLincs pays its Benefits **secondary** to Medicare, Members should always submit the Medicare "explanation of benefits" (EOB) form along with any statements of services rendered when filing claims for **secondary** benefits with BlueLincs.

F. AMENDMENT RESPECTING ADVERSE BENEFIT DETERMINATION

The ***Member Complaints and Appeals*** section is amended so that the definition of "Adverse Benefit Determination" is hereby deleted and replaced by the following:

An "Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental, Investigational or Unproven or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by us and reduces or terminates such treatment (other than by amendment or termination of this Member Handbook) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

G. AMENDMENT RESPECTING EXTERNAL REVIEW RIGHTS

Your Member Handbook is amended so that the provisions outlining "External Review Rights" as set forth in the ***Member Complaints and Appeals*** section are hereby deleted and restated as follows:

EXTERNAL REVIEW RIGHTS

If you receive an Adverse Benefit Determination, you may have a right to have our decision reviewed by independent health care professionals who have no association with us ***if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment.*** The request for a standard external review by an Independent Review Organization (IRO) must be submitted within four months after you receive notice of the internal appeal determination. For a standard review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may request an **expedited external review** of our denial before your internal review rights have been exhausted. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is Experimental, Investigational or Unproven, you also may be entitled to file a request for external review of our denial.

You or your authorized representative may file a request for a standard or expedited external review by completing the required forms and submitting them directly to the address noted below. We will also provide the forms to you upon request.

Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152-3408
Telephone: 1-800-522-0071 (Oklahoma only)
405-521-2828

There will be no charge to you for the IRO review. The IRO will notify you and/or your authorized representative of its decision, which will be binding on BlueLincs and on you, except to the extent you have additional remedies available.

For questions or assistance regarding the right to an external review by an independent review organization, the Member may call Customer Service at the number found on the back of their Identification Card. Members may also contact the Oklahoma Insurance Department at the following address:

Oklahoma Insurance Department
3625 NW 56th Street
Oklahoma City, OK 73112-4511
http://www.ok.gov/oid/Consumers/index.html
Telephone: 1-800-522-0071 or 405-521-2828

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

The above changes to your Group Health Plan are effective on the first of the following dates occurring on or after January 1, 2016:

1. **the Agreement Effective Date;**
2. **the Group's first Agreement Date Anniversary (renewal date); or**
3. **the first Plan Year of the Group Health Plan.**

BlueLincs HMO

Chief Executive Officer

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

A. **AMENDMENT RESPECTING DEPENDENT ELIGIBILITY**

The term "Dependent child", wherever used in the Member Handbook is amended to include an eligible foster child.

B. **AMENDMENT RESPECTING NON-DISCRIMINATION**

You will not be discriminated against for coverage under this Group Health Plan on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variations in the administration, processes or benefits of this Member Handbook that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

C. **AMENDENT RESPECTING ENROLLMENT WAITING PERIOD**

The ***Eligibility, Enrollment, Changes and Termination*** section of your Member Handbook is amended by the addition of the following provision:

If your Group has a waiting period prior to the Effective Date of your coverage, such waiting period may not exceed 90 days, unless permitted by applicable law. If our records show that your Group has a waiting period that exceeds the time period permitted by applicable law, then we reserve the right to begin your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, your Group is responsible for your waiting period. If you have questions about your waiting period, please contact your Group Administrator.

D. **AMENDMENT RESPECTING ELIGIBILITY, ENROLLMENT, CHANGES AND TERMINATION**

The ***Eligibility, Enrollment, Changes and Termination*** section is amended as follows:

1. Any reference to the terms "material misrepresentation", "misrepresentation" or "intentional misrepresentation" are replaced by "intentional misrepresentation of material fact".
2. The provisions of this section under the heading *"When Coverage Under This Member Handbook Ends"* are hereby deleted and restated as follows:

WHEN COVERAGE UNDER THIS MEMBER HANDBOOK ENDS

When a Member is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the coverage period (billing period) during which eligibility ceases, except as follows:

- A Member's COBRA Continuation Coverage, when applicable, will cease on the earliest to occur of the following dates:
  - the date the coverage period ends following expiration of the 18-month, 29-month or 36-month COBRA Continuation Coverage period, whichever is applicable;

- the first day of the month that begins more than 30 days after the date of the Social Security Administration's final determination that the Member is no longer disabled (when coverage has been extended from 18 months to 29 months due to disability);
- the date on which the Group stops providing any Group Health Plan to any Employee;
- the date on which coverage stops because of a Member's failure to pay to the Group any premiums required for the COBRA Continuation Coverage;
- the date on which the Member first becomes (after the date of the election) covered under any other Group Health Plan which does not contain any exclusion or limitation with respect to a preexisting condition applicable to the Member (or the date the Member has satisfied the preexisting condition exclusion period under that plan); or
- the date on which the Member becomes (after the date of the election) entitled to benefits under Medicare.

- Your coverage will terminate retroactive to your Effective Date if you or the Group commits fraud or intentional misrepresentation of a material fact in applying for or obtaining coverage under the Agreement. Your coverage will end immediately if you file a fraudulent claim.
- If your premiums are not paid, your coverage will stop at the end of the coverage period for which your premiums have been paid.
- Termination of the Agreement automatically ends all of your coverage at the same time and date. It is the responsibility of your Group to tell you of such termination.
- In the case of an Employee whose coverage is terminated under a Group Health Plan that is not subject to COBRA Continuation Coverage, such Employee and his/her Dependents shall remain insured under the Plan for a period of 63 days after such termination, unless during such period the Employee and his/her Dependents shall otherwise become entitled to similar insurance from some other source.
- When a Member ceases to be an Eligible Dependent by reason of divorce, coverage for that Member will cease on the date the divorce is granted or on the date specified by the Member's spouse whichever is earlier, unless superseded by a court order.
- When a Member ceases to be an eligible Dependent by reason of death, coverage for that Member will cease on the date of death.
- When a Member ceases to be an Eligible Dependent child because he/she has reached the age limit for Dependent children (unless medically certified as Totally Disabled). Check with your Group Administrator for Dependent age limitations.
- Coverage of the Member shall terminate on the date the Member becomes covered under the Employer's Alternate Health Plan (if applicable).
- When a Subscriber moves out of the BlueLincs Service Area and does not work within the BlueLincs Service Area, coverage for the Subscriber and his/her Dependents, if any, shall terminate under the Agreement on the date of the change in permanent residence.
- If applicable, adjustments in premium will be paid to the Group in accordance with the billing practices established for the Group.

E. AMENDMENT RESPECTING MEDICAL NECESSITY

The ***Definitions*** section is amended so that the definition of "Medically Necessary (or Medical Necessity)" is hereby deleted and replaced by the following definition:

Medically Necessary (or Medical Necessity) – Health care services that BlueLincs determines a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

F. AMENDMENT RESPECTING CREDITABLE COVERAGE

The *"Certificates of Creditable Coverage"* provisions of the Group Health Plan are hereby removed and shall no longer apply to any Member.

G. AMENDMENT RESPECTING BENEFIT MAXIMUMS

The ***Schedule of Benefits*** is amended as set forth below:

1. The 300-day lifetime maximum for Skilled Nursing Facility/Inpatient rehabilitation services is hereby removed.
2. Benefits for wigs and scalp prostheses are limited to a maximum of one per Benefit Period. The Benefit Period dollar maximum is hereby removed.
3. Outpatient physical therapy, occupational therapy and speech therapy are limited to a maximum of 60 visits per Benefit Period. The maximum of "60 consecutive calendar days per condition" is hereby removed.

H. AMENDMENT RESPECTING SERVICES RELATED TO CLINICAL TRIALS

The Member Handbook is amended so that the provisions under *"Services Related to Clinical Trials"* are hereby deleted and restated as follows:

SERVICES RELATED TO CLINICAL TRIALS

Benefits for Routine Patient Costs when provided in connection with a phase I, phase II, phase III, or phase IV clinical trial, if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

- Any of the following federally funded or approved trials:
  - The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
  - The National Institutes of Health (NIH);
  - The Centers for Medicare and Medicaid Services;
  - The Agency for Healthcare Research and Quality;
  - A cooperative group or center of any of the previous entities;
  - The United States Food and Drug Administration;
  - The United States Department of Defense (DOD);
  - The United States Department of Veterans Affairs (VA);
  - A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system; or
  - An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.
- A clinical trial conducted under an FDA investigational new drug application.
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Benefits may not be available under this section for services that are paid for by the research institution conducting the clinical trial.

For purposes of this provision, "Routine Patient Costs" generally include all items and services consistent with the coverage provided under the Member Handbook for an individual with a similar condition who is not enrolled in a clinical trial. However, costs associated with the following are *not* Covered Services:

- The cost of the investigational item, device or service;
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management;
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- The cost for a clinical trial that does not meet criteria established by applicable law.

I. AMENDMENT RESPECTING SMOKING CESSATION

If your Outpatient Prescription Drug Benefits include an exclusion for smoking cessation products, that exclusion will no longer apply.

J. AMENDMENT RESPECTING OUTPATIENT PRESCRIPTION DRUGS

The ***Prescription Drug Benefits*** section of your Member Handbook and the ***Prescription Drug Schedule of Benefits*** (if applicable) are amended as set forth below:

Coverage of prescribed orally administered anticancer medications will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

K. AMENDMENT RESPECTING EXCLUSIONS

The "*Exclusions and Limitations"* set forth in the ***Schedule of Benefits*** are amended as follows:

– The following exclusion is hereby added:

  - Acupuncture, whether for medical or anesthesia purposes.

– The exclusion for "elective abortions" is hereby deleted and replaced by the following exclusion:

  - For elective abortion, unless the life of the mother is endangered.

L. AMENDMENT RESPECTING WORKER'S COMPENSATION

The provisions outlining *"Work-Related Illness or Injury",* as set forth in the ***General Provisions*** section, are deleted in their entirety and replaced by the following provisions:

WORK-RELATED ILLNESS OR INJURY

BlueLincs will not exclude coverage for any injury or illness occurring in the course of employment for which whole or partial compensation or benefits are or might be available under the laws of any government unit, any policy of workers' compensation insurance; an employer's insured and/or self-funded workers' compensation or any other plan providing coverage for work-related illness or injury; or according to any recognized legal remedy arising from an Employer-Employee relationship.

- However, BlueLincs and the Member agree that the Member will:
  – pursue his or her rights under the worker's compensation laws; and
  – take no action prejudicing the right and interests of BlueLincs; and
  – cooperate and furnish such information and assistance BlueLincs requires to facilitate enforcement of its rights.
- If the Member receives any money in in settlement of an Employer's liability, regardless of whether the settlement includes a provision for payment of his/her medical bills, the Member agrees to hold in trust said money for the benefit of BlueLincs and to repay BlueLincs any money recovered from the Employer or insurance carrier to the extent that BlueLincs has paid any benefits or would be obligated to pay any benefits.

M. AMENDMENT RESPECTING NOTICE AND PROPERLY FILED CLAIM

The ***Methods of Payment and Claims Filing*** section is amended so that the reference to 90 days for submission of a Properly Filed Claim are removed and replaced by the following:

Your Properly Filed Claim must be furnished to BlueLincs within 180 days following the end of the Benefit Period for which the claim is made.

N. AMENDMENT RESPECTING COORDINATION OF BENEFITS

The ***General Provisions*** section is amended so that the provisions outlining *"Coordination of Benefits"* are deleted in their entirety and replaced by the following:

COORDINATION OF BENEFITS

When a Member or a Dependent has health coverage with more than one health plan, there will be times when the two health plans will need to coordinate benefit coverage to decide who is responsible for payment to Providers. This is called coordination of benefits (COB).

Please note that this section only applies if the Member or Dependent has health coverage under more than one plan.

Definitions

In addition to the definitions listed on the back of this Agreement, the following apply to this COB provision:

- "**Other Agreement**" means any arrangement providing health care benefits or services through:
  - group, group-type, blanket, franchise insurance coverage or any other insurance coverage permitted by state law or Oklahoma Insurance Department guidance;
  - Blue Cross, Blue Shield, Health Maintenance Organization and other prepayment coverage;
  - Coverage under labor-management trusteed plans, union welfare plans, Employer organization plans or employee benefit organization plans;
  - coverage toward the cost of which any Employer has contributed, or with respect to which any Employer has made payroll deductions; and
  - coverage under any tax supported or government program, including Medicare, to the extent permitted by law.

Coverage under specific benefit arrangements, such as dental care or vision care benefit plans that are not part of a comprehensive health care benefit plan, shall be excluded from the definition of "Other Agreement" herein.

- **"Covered Service"** additionally means a service or supply furnished by a Hospital, Physician or other Provider for which benefits are provided under at least one Other Agreement covering the person for whom the claim is made or service provided.
- **"Dependent"** additionally means a person who qualifies as a Dependent under an Other Agreement.
- **"Primary Plan"** means the coverage that pays benefits or provides services first under the Order of Benefit Determination Rules below.
- **"Secondary Plan"** means any other coverage that is not a Primary Plan.

All Benefits provided under the Agreement are subject to this COB provision.

It is the responsibility of each Member to advise BlueLincs of his or her participation in any Other Agreement. We will occasionally request information from you regarding duplicate health coverage. This information is also requested on the BlueLincs application. Please complete and return the requested information promptly to ensure timely processing of your claims.

BlueLincs follows the COB rules established by state law, including the rules for determining the order in which Benefits are to be paid on behalf of Dependent children. Therefore, our Members do not have the option of choosing which plan they wish to have pay benefits first.

All Covered Services (except where Medicare is primary) must be preauthorized or precertified by your PCP and/or BlueLincs in accordance with the provisions of this Agreement and any Schedule(s) of Benefits.

Medicare

When Medicare is the primary payer, you may seek services from any Participating Medicare Provider.

Your Plan provides primary coverage for the following covered Medicare-eligible individuals:

- Active Employees and their spouses or Domestic Partners, **unless coverage is through an Employer with 20 Employees or less**;
- Members who are on renal dialysis for 30 months or less; and
- Members who are under 65 and who are eligible for Medicare by reason of disability.

For all other Medicare beneficiaries, Medicare is the primary carrier.

While primary medical coverage is being provided under this Plan, you may wish to enroll in Medicare, as expenses not reimbursed under this Plan may be reimbursed under Medicare. Be sure to apply for Medicare Part A (Hospital Insurance) and Part B (supplemental medical insurance) at least three months before your 65th birthday.

When Medicare provides primary coverage, this Plan will reduce Benefits payable for Covered Services by any benefits payable for the same Covered Services under Medicare.

When BlueLincs pays its Benefits **secondary** to Medicare, Members should always submit the Medicare "explanation of benefits" (EOB) form along with any statements of services rendered when filing claims for **secondary** benefits with BlueLincs.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

The above changes to your Group Health Plan are effective on the first of the following dates occurring on or after January 1, 2015:

1. **the Agreement Effective Date;**
2. **the Group's first Agreement Date Anniversary (renewal date); or**
3. **the first Plan Year of the Group Health Plan.**

BlueLincs HMO

Chief Executive Office

Blue Cross and Blue Shield of Oklahoma

1400 South Boston • P.O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended as set forth below:

A. **AMENDMENT RESPECTIVE WOMEN'S PREVENTIVE SERVICES**

Benefits for "Breast-feeding Support, Services and Supplies" are amended to read as follows:

Benefits will be provided for breast-feeding counseling and support services rendered by a Provider for pregnant and postpartum women. Benefits include the rental (or, at BlueLincs' option, the purchase) of manual or electric breast-feeding equipment.

B. **AMENDMENT RESPECTING EXCLUSIONS AND LIMITATIONS**

The "*Exclusions and Limitations*" set forth in the ***Schedule of Benefits***, are amended as follows:

1. The exclusion for "services rendered by midwives" shall no longer be applicable.
2. The exclusion for "elective abortions" is hereby removed and replaced by the following exclusion:

   Benefits will not be provided for any services related to elective abortion, unless the life or health of the mother is endangered.

C. **AMENDMENT RESPECTING OUT-OF-AREA SERVICES**

The "BlueCard" provisions of your Member Handbook are hereby deleted and replaced by the following:

OUT-OF-AREA SERVICES

BlueLincs HMO has relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Whenever you obtain health care services outside of our Service Area, the claims for these services may be processed through one of these Plans.

Typically, when accessing care outside our Service Area, you will obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating health care Providers. Our reimbursement practices in both instances are described below.

BlueLincs covers only limited health care services received outside of our Service Area. As used in this section, "Out-of-Area Covered Health Care Services" include Emergency Care or Urgent Care obtained outside the geographic area we serve. Follow-up care following an emergency is also available, provided the services are preauthorized by BlueLincs. Any other services will not be eligible for benefits unless authorized by BlueLincs.

- **BlueCard® Program**

  Under the BlueCard® Program, when you obtain Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

  The BlueCard Program enables you to obtain services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating health care Provider will automatically file a

claim for the services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment, Coinsurance and/or Deductible amount, as stated in your Member Handbook.

Whenever you access covered health care services outside our Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

– The billed charges for your Covered Services; or

– The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group. Occasionally, it may be an average price for similar types of health care Providers.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your responsibility for any Covered Services according to applicable law.

- **Non-Participating Health Care Providers Outside the BlueLincs Service Area**

  – **Your Liability Calculation**

    When Out-of-Area Covered Health Care Services are received from non-participating Providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment we will make for the Covered Services as set forth in your Member Handbook.

  – **Exceptions**

    BlueLincs may determine the amount we will pay for services rendered by non-participating health care Providers, if pricing arrangements are not available from the Host Blue or applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment we will make for the Covered Services as set forth in your Member Handbook.

NOTE: BlueLincs may postpone or waive application of your Copayment, Coinsurance and/or Deductible whenever it is necessary in order to obtain Provider discounts for Covered Services you receive outside the state of Oklahoma.

D. **AMENDMENT RESPECTING RIGHT OF RECOUPMENT**

The ***Other Coverage and Right of Recoupment*** section of the Member Handbook is amended by deletion of the following sentence under the "Right of Recoupment" provisions:

"Failure to comply with the above provisions may result in termination of your coverage and/or legal action to enforce collection."

E. **AMENDMENT RESPECTING RELIGIOUS EMPLOYER EXEMPTION AND ELIGIBLE ORGANIZATION ACCOMMODATION**

A certification(s) may have been provided to BlueLincs HMO that your Group Health Plan is established or maintained by an organization(s) that is a "religious employer(s)" as defined in 45 C.F.R. 147.131(a), as modified or replaced, and qualifies for a religious employer exemption from the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Religious Employer Exemption"). Provided that the Religious Employer Exemption is satisfied for your Group Health Plan, then coverage under your Group Health Plan, as set forth under "*Preventive Care Services"*, will not include coverage for some or all of such contraceptives services (please call Customer Service at the number on the back of your Identification Card for more information). Questions regarding the Religious Employer Exemption should be directed to your Group Administrator.

In addition, a certification(s) may have been provided to BlueLincs HMO that your Group Health Plan is established or maintained by an organization(s) that is an "eligible organization(s)" as defined in 45 C.F.R. 147.131(b), as modified or replaced, and qualifies for an eligible organization accommodation with respect to the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Eligible Organization Accommodation"). Provided that the Eligible Organization Accommodation is satisfied, coverage under your Group Health Plan, as set forth under *"Preventive Care Services"*, will not include coverage for some or all of such contraceptives services. If you have questions regarding the certification(s), you may contact your Group Administrator. For other questions about the Eligible Organization Accommodation, you may contact Customer Service at the number on the back of your Identification Card.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

The above changes to your Group Health Plan are effective on the first of the following dates occurring on or after January 1, 2014:

1. **the Agreement Effective Date;**
2. **the Group's first Agreement Date Anniversary (renewal date); or**
3. **the first Plan Year of the Group Health Plan.**

BlueLincs HMO

Chief Executive Officer

Blue Cross and Blue Shield of Oklahoma

1400 South Boston • P.O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS RESPECTING WOMEN'S PREVENTIVE CARE SERVICES

IT IS AGREED that the Member Handbook to which this amendment is issued for attachment is amended by the addition of the following provisions:

A. **AMENDMENT RESPECTING PREVENTIVE CARE SERVICES**

Preventive Care Services with respect to women are amended to include the following Covered Services when performed by Participating Providers and will not be subject to Deductible, Copayment, Coinsurance or dollar maximums:

1. Breastfeeding Support, Services and Supplies – Benefits will be provided for breastfeeding counseling and support services rendered by a Participating Providers for pregnant and postpartum women. Benefits include the rental (or, at the Plan's option, the purchase if it will be less expensive) of ***manual*** breast pumps, accessories and supplies.
2. Contraceptive Services – Benefits will be provided for the following contraceptive services when prescribed by a licensed Participating Provider for women with reproductive capacity:

   - contraceptive counseling;
   - FDA-approved prescription devices and medications;
   - over-the-counter contraceptives; and
   - sterilization procedures (tubal ligation), but not including hysterectomy.

   Coverage includes contraceptives in the following categories:
   - progestin-only contraceptives;
   - combination contraceptives;
   - emergency contraceptives;
   - extended-cycle/continuous oral contraceptives;
   - cervical caps;
   - diaphragms;
   - implantable contraceptives;
   - intra-uterine devices;
   - injectables;
   - transdermal contraceptives and
   - vaginal contraceptive devices.

NOTE: Prescription contraceptive medications are covered under the ***Prescription Drug Benefits*** section of your Member Handbook**,** or ***Prescription Drug Schedule of Benefits*****,** *if applicable*.

The contraceptive drugs and devices listed above may change as FDA guidelines are modified. Coinsurance or Copayment amounts will not apply to FDA-approved contraceptive drugs and devices on the Contraceptive Information list. You may access the Web site at www.bcbsok.com or contact customer service at the toll-free number on your Identification Card.

When obtaining the items noted above, you may be required to pay the full cost and then submit a claim form with itemized receipts to BlueLincs for reimbursement. Please refer to the ***Methods of Payment and Claim Filing*** section of your Member Handbook for claims submission information.

Covered Preventive Care Services received from non-Participating Providers and/or non-Participating Retail Pharmacies, or other routine Covered Services not provided for under this provision may be subject to Deductible, Copayment, Coinsurance and/or benefit maximums.

B. **AMENDMENT RESPECTING EXCLUSIONS**

The exclusion of contraceptive medications or devices shown in the ***Exclusions*** section is hereby removed and replaced with the following:

- For female contraceptive devices when not prescribed by a licensed Provider, including over-the-counter contraceptive products. Contraceptive medications or devices for male use are excluded.

C. AMENDMENT RESPECTING CONTRACEPTIVE COVERAGE

If your Group has indicated to BlueLincs that it qualifies for a one-year temporary exemption or a permanent exemption with respect to the federal requirement to cover contraceptive services without cost sharing, coverage under this Plan will not include coverage for contraceptive services. Questions regarding this exemption should be directed to your Group Administrator.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

For Agreements in effect on or after August 1, 2012, this amendment is effective on the Agreement Effective Date or Agreement Date Anniversary.

BlueLincs HMO

Chief Executive Officer

Blue Cross and Blue Shield of Oklahoma

1400 South Boston • P.O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENT RESPECTING OUTPATIENT PRESCRIPTION DRUG BENEFITS

Effective January 1, 2012, or your Effective Date, if later, your Member Handbook is amended by the addition of the following special provisions.

A. The ***Prescription Drug Benefits*** section of your Member Handbook, and the ***Prescription Drug Schedule of Benefits*** **(if applicable)** are amended as set forth below

- **PARTICIPATING PHARMACY NETWORK**

  For purposes of the Outpatient Prescription Drug Benefits provisions of your Member Handbook, the term "Participating Pharmacy" or "Participating Retail Pharmacy" shall mean pharmacies who have entered into an agreement to be a part of the BlueLincs Pharmacy Network. This definition shall replace any other definition of the term "Participating Pharmacy" in your Member Handbook or in any Schedule of Benefits or amendment attached thereto.

  To find a Pharmacy in the BlueLincs Pharmacy Network, please refer to our Web site at www.bcbsok.com or call a Customer Service representative at the number shown on your identification card.

- **PRESCRIPTION DRUG SUPPLY/DISPENSING LIMITS**

  BlueLincs HMO has the right to determine the day supply or unit dosage limits at its sole discretion. Payment for benefits covered under your Member Handbook may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum supply limitations.

  – **Benefit Supply Limits per Prescription**

    For each Copayment or Coinsurance amount specified for your Prescription Drug Program, you can obtain the following supply of a single Prescription Drug or other item covered under this program (unless otherwise specified):

    - During each one-month period, up to a 30-day supply or 120 units (e.g. pills), whichever is less, for "non-maintenance" and Specialty Pharmacy Drugs. If more than 120 units are needed to reach a 30-day supply, another Copayment or Coinsurance amount will apply to each additional 120 units (or portion thereof) purchased.
    - During each three-month period, up to a 90-day supply or 360 units (e.g. pills), whichever is less for drugs designated by the Plan as Maintenance Prescription Drugs. If less than a 90-day supply is ordered, the mail-order Copayment or Coinsurance will still apply. If more than 360 units are needed to reach a 90-day

supply, an additional mail-order Copayment or Coinsurance amount will apply to each additional 360 units (or portion thereof) purchased.

For commercially packaged items (such as an inhaler, a tube of ointment, or a blister pack of tablets or capsules), you will pay the applicable Copayment or Coinsurance amount for each package, regardless of the days' supply the package represents. For example, if two inhalers are purchased under the retail Pharmacy, two Copayment or Coinsurance amounts will apply. Under the mail-order program, you can receive up to three times the number of packages obtainable from a retail Pharmacy for the applicable mail-order Copayment or Coinsurance amount.

Benefits are not provided under your Member Handbook for charges for Prescription Drugs dispensed in excess of the above stated amounts.

If you are leaving the country or need an extended supply of medication, call Customer Service at least two weeks before you intend to leave. Extended supplies or vacation override are not available through the mail-order program but may be approved through a retail Pharmacy only. In some cases, you may be asked to provide proof of continued enrollment eligibility under this Prescription Drug program.

NOTE: The Prescription Drug quantity limits specified above shall supersede any previous quantity limits specified in your Member Handbook, Schedule of Benefits, or in any rider or amendment issued thereto.

– **Clinical Dispensing Limits Applicable to Certain Drugs**

In addition to the supply limits stated above and regardless of the quantity of a covered drug prescribed by a Physician, BlueLincs has the right to establish dispensing limits on covered drugs. These limits, which are based upon FDA dosing recommendations and nationally recognized clinical guidelines, identify gender or age restrictions, and/or the maximum quantity of a drug (or member of a drug class) that can be dispensed to you over a specific period of time. Such limits are in place to encourage appropriate drug use, patient safety, and reduce stockpiling. Benefits for a covered drug may also be denied if the drug is dispensed or delivered in a manner intended to avoid the BlueLincs-established dispensing limit. If you need a drug quantity that exceeds the dispensing limit, ask your doctor to submit a request for review to BlueLincs on your behalf. The Preauthorization request will be approved or denied after the clinical information submitted by the prescribing doctor has been evaluated by BlueLincs.

- **EXCLUSIONS AND LIMITATIONS**

In addition to the exclusions and limitations specified in the ***Exclusions*** section of your Member Handbook and any Schedule of Benefits, no benefits will be provided under this ***Outpatient Prescription Drug Benefits*** section for:

– Drugs which by law do not require a Prescription Order from an authorized Provider (except insulin, insulin analogs, insulin pens, and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription Order is obtained.

– Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (**except** glucose meters, lancets, test strips and disposable hypodermic needles and syringes for self-administered injections.) However, coverage for prescription contraceptive devices is provided under the medical benefits provisions of your Member Handbook.

- Administration or injection of any drugs (except for vaccines administered by a Participating Pharmacy).
- Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).
- Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Prescription Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any Prescription Drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that this exclusion shall not be applicable to any coverage held by you for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Infertility medications and fertility medications; prescription contraceptive devices or non-prescription contraceptive materials (**except** oral contraceptive medications which are Prescription Drugs). However, coverage for prescription contraceptive devices is provided under the medical benefits provisions of your Member Handbook.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or Experimental drugs, even though a charge is made for the drugs.
- Prescription Drugs or devices dispensed in quantities in excess of the amounts stipulated in this ***Outpatient Prescription Drug Benefits*** section; or refills of any prescriptions in excess of the number of refills specified by the Physician or by law; or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
- Fluids, solutions, nutrients, medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically provided in your Member Handbook and its Schedule(s) of Benefits. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.

- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Any smoking cessation products, including those which require a Prescription Order.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- Athletic performance enhancement drugs.
- Drugs used or intended to be used in the treatment to stimulate growth, including, but not limited to, self-administered injectable drugs.
- Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine.
- Compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA-approved manufacturer directions consistent with that labeling.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.
- Drugs which are repackaged by anyone other than the original manufacturer.

B. The ***General Provisions*** section of your Handbook, is amended so that the "PHARMACY BENEFIT ADMINISTRATION" provisions are hereby deleted and replaced by the following provisions:

- **BLUELINCS HMO'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS**

  BlueLincs hereby informs you that it has contracts, either directly or indirectly, with Participating Prescription Drug Providers for the provision of, and payment for, Prescription Drug services to all persons entitled to Prescription Drug Benefits under individual certificates, group health insurance policies and contracts to BlueLincs is a party, including this Handbook, and that pursuant to BlueLincs' contracts with Participating Prescription Drug Providers, under certain circumstances described therein, BlueLincs may receive discounts for Prescription Drugs dispensed to you. Actual discounts used to calculate your share of the cost of Prescription Drugs will vary. Some discounts are currently based on Average Wholesale Price ("AWP") which is determined by a third party and is subject to change.

  You understand that BlueLincs may receive such discounts. You are not entitled to receive any portion of any such discounts. The drug fees/discounts that BlueLincs has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate your share of the cost of Prescription Drugs for both retail and mail/specialty drugs. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to BlueLincs (and ultimately to you as described above).

  To help you understand how BlueLincs' separate financial arrangements with Participating Prescription Drug Providers work, please consider the following example:

- Assume you have a prescription dispensed and the undiscounted amount of the Prescription Drug is $100. How is the $100 bill paid?
- You will have to pay the Copayment or Coinsurance amount set out in this Handbook.
- However, for purposes of calculating your Coinsurance amount, the full amount of the Prescription Drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 Prescription Drug bill would be reduced by 20% to $80 for purposes of calculating your Coinsurance amount.
- In our example, if your Coinsurance obligation is 30%, you will have to pay 30% of $80, or $24. You should note that your 30% Coinsurance amount is based upon the discounted amount of the prescription and not the full $100 bill.

For the mail pharmacy and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail pharmacy and/or specialty pharmacy program. BlueLincs pays a fee to Prime for pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and mail-order processing.

"Weighted paid claim" refers to the methodology of counting claims for purposes of determining BlueLincs' fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim equals one weighted paid claim; each extended supply or mail order (including Mail Service) paid claim equals three weighted paid claims. However, BlueLincs pays Prime a Program Management Fee ("PMF") on a per paid claim basis. "Funding Levers" means a mechanism through which BlueLincs funds the fees (net fee, ancillary fees and special project fees) owed to PBM. Funding Levers always include manufacturer administrative fees, mail order utilization, participating pharmacy transaction fees, and, if elected by BlueLincs, may include rebates and retail spread. BlueLincs' net fee owed to Prime for core services will be offset by the Funding Levers. The Plan pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable Funding Levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per Weighted Paid Claim.

The amounts received by Prime from BlueLincs, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to BlueLincs (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Handbook. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of BlueLincs and other Blue Plan operating divisions.

- **BLUELINCS HMO'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS**

  BlueLincs hereby informs you that it owns a significant portion of the equity of Prime and that BlueLincs has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, Prescription Drug Benefits to all persons entitled to Prescription Drug Benefits under

individual certificates, group health insurance policies and contracts to which BlueLincs is a party, including this Handbook. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, Prime's mail order pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of BlueLincs, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). BlueLincs may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

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Except as amended, your Member Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR MEMBER HANDBOOK FOR FUTURE REFERENCE.

Chief Executive Officer of BlueLincs HMO

Blue Cross and Blue Shield of Oklahoma

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AMENDMENT RESPECTING MEMBER COMPLAINTS AND APPEALS

IT IS AGREED that the **Member Handbook** to which this amendment is issued for attachment is amended as set forth below:

A. The **"Preauthorization/Precertification"** provisions are amended so that the paragraph entitled "Precertification/Precertification Requests Involving Urgent Care" is hereby deleted and replaced by the following:

- **Preauthorization/Precertification Requests Involving Urgent Care**

  A "Preauthorization/Precertification Request Involving Urgent Care" is any request for Medical Care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

  – could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or

  – in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Preauthorization/Precertification request.

  In case of a "Preauthorization/Precertification Request Involving Urgent Care," BlueLincs will respond to you no later than 72 hours after receipt of the request, unless you fail to provide sufficient information, in which case, you will be notified of the missing information within 24 hours and will have no less than 48 hours to provide the information. A benefit determination will be made as soon as possible (taking into account medical exigencies) but no later than 72 hours after the initial request, or within 48 hours after the missing information is received (if the initial request is incomplete).

B. **AMENDMENT RESPECTING MEMBER COMPLAINTS AND APPEALS**

The **"Member Complaints and Appeals"** section currently reflected in the Member Handbook, or in any amendment attached thereto, are hereby deleted and restated as follows:

MEMBER COMPLAINTS AND APPEALS

BlueLincs HMO has established the following process to review your dissatisfactions, complaints, and/or appeals. If you have designated an authorized representative, that person may act on your behalf in the appeal process.

If you have a question or complaint, an initial attempt should be made to resolve the problem by directly communicating with a BlueLincs Member Services Representative. In most cases, a Member Services Representative will be able to provide you with a satisfactory solution to your problem. However, if a resolution cannot be reached in an informal exchange, you may request an administrative review of the problem through our appeal process described below.

You may request to review information used to make any adverse determination. Copies will be provided free of charge.

CLAIM DETERMINATIONS

When BlueLincs receives a Properly Filed Claim, it has authority and discretion under this Plan to interpret and determine benefits in accordance with the Member Handbook provisions. We will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing.

You have the right to seek and obtain a full and fair review by BlueLincs of any determination of a claim, any determination of a request for Preauthorization/Precertification, or any other determination of your benefits made by BlueLincs under this Plan.

IF A CLAIM IS DENIED OR NOT PAID IN FULL

On occasion, we may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the Explanation of Benefits summary prepared by us; then review this Member Handbook to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to us and request a review of the decision as described in "Claim Appeal Procedures" below.

If the claim is denied in whole or in part, you will receive a written notice from us with the following information, if applicable:

- The reasons for the determination;
- A reference to the benefit provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);

- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by us;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claims. An urgent care claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

TIMING OF REQUIRED NOTICES AND EXTENSIONS

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. Claim refers to a request for benefit(s). There are three types of claims, as defined below.

- **"Urgent Care Claim"** is any pre-service request for benefit(s) that requires Preauthorization/Precertification, as described in this Member Handbook, for benefits for Medical Care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.
- **"Pre-Service Claim"** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining Medical Care.
- **"Post-Service Claim"** is any request for a benefit that is not a "pre-service" claim, and whereby notification that a service has been rendered or furnished to you is submitted to BlueLincs in an acceptable form. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which we may request in connection with services rendered to you.

URGENT CARE CLAIMS*

Type of Notice or Extension	Timing
If your claim is incomplete, we must notify you within:	**24 hours**
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	**48 hours** after receiving notice
If we deny your initial claim, we must notify you of the denial:	
if the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**

* You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call us at the toll-free number listed on the back of your Identification Card as soon as possible to appeal an Urgent Care Clinical Claim.

PRE-SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is filed improperly, we must notify you within:	**5 days**
If your claim is incomplete, we must notify you within:	**15 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	**45 days** after receiving notice
If we deny your initial claim, we must notify you of the denial:	
if the initial claim is complete, within:	**15 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**

* This period may be extended one time by BlueLincs for up to 15 days, provided that BlueLincs both (1) determines that such an extension is necessary due to matters beyond the control of BlueLincs and (2) notifies you, prior to the expiration of the initial 15−day period, of the circumstances requiring the extension of time and the date by which BlueLincs expects to render a decision.

POST-SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is incomplete, we must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	**45 days** after receiving notice
If we deny your initial claim, we must notify you of the denial:	
if the initial claim is complete, within:	**30 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

* This period may be extended one time by BlueLincs for up to 15 days, provided that BlueLincs both (1) determines that such an extension is necessary due to matters beyond the control of BlueLincs and (2) notifies you in writing, prior to the expiration of the initial 30–day period, of the circumstances requiring the extension of time and the date by which BlueLincs expects to render a decision.

CLAIM APPEAL PROCEDURES

- ***Claim Appeal Procedures - Definitions***

  An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental, Investigational or unproven or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by us and reduces or terminates such treatment (other than by amendment or termination of this Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

  A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by BlueLincs at completion of the internal review/appeal process.

- ***Urgent Care/Expedited Clinical Appeals***

  If your situation meets the definition of an Expedited Clinical Appeal, you may be entitled to an appeal on an expedited basis. An **Expedited Clinical Appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care Provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, we will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, we will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. BlueLincs shall render a determination on the appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

- ***How to Appeal an Adverse Benefit Determination***

  You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization/Precertification, or any other determination made by us in accordance with the benefits and procedures detailed in your Member Handbook.

  An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care Provider may appeal on his/her own behalf. Your designation of a representative must be in writing, as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call us at the number on the back of your Identification Card.

  If you believe we incorrectly denied all or part of your benefits, you may have your claim reviewed. We will review its decision in accordance with the following procedure:

  – Within 180 days after you receive notice of a denial or partial denial, you may call or write to our Administrative Office. We will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

    Appeal Coordinator – Member Services Department
    BlueLincs HMO
    P.O. Box 3283
    Tulsa, Oklahoma 74102-3283

  – We will honor telephone requests for information. However, such inquiries will not constitute a request for review.

  – In support of your claim review, you have the option of presenting evidence and testimony to us. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

    We will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. Clinical appeal determinations may be made by a Physician associated or contracted with us and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by us.

- If you have any questions about the claims procedures or the review procedure, write to our Administrative Office Member Services Representative at the number shown on your Identification Card.

- ***Timing of Appeal Determinations***

  Upon receipt of a non-urgent pre-service appeal, we shall render a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by us.

  Upon receipt of a non-urgent post-service appeal, we shall render a determination of the appeal as soon as practical, but in no event more than 60 days (or 30 days if the determination involves a Medical Necessity/appropriateness or Experimental, Investigational or unproven decision) after the appeal has been received by us.

- ***Notice of Appeal Determination***

  We will notify the party filing the appeal, you, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal, by a written notice of the determination.

  The written notice will include:
  - A reason for the determination;
  - A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
  - Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
  - An explanation of our external review processes (and how to initiate an external review);
  - In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other benefit information may be available (upon request) in such non-English language(s);
  - In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by us;
  - The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
  - Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
  - An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
  - A description of the standard that was used in denying the claim and a discussion of the decision; and
  - Contact information for applicable office of health insurance consumer assistance or ombudsman.

EXTERNAL REVIEW RIGHTS

If you receive an Adverse Benefit Determination, you may have a right to have our decision reviewed by independent health care professionals who have no association with us ***if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment.*** The request for an external review by an Independent Review Organization (IRO) must be submitted within four months after you receive notice of the internal appeal determination. You or your authorized representative may file a request for

external review by completing the required forms and submitting them directly to the address noted below. We will also provide the forms to you upon request.

Oklahoma Insurance Department
3625 NW 56th Street
Oklahoma City, OK 73112-4511
Telephone: 1-800-522-0071 or 405-521-2828

For a standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is Experimental or Investigational, you also may be entitled to file a request for external review of our denial.

There will be no charge to you for the IRO review. The IRO will notify you and/or your authorized representative of its decision, which will be binding on BlueLincs and on you, except to the extent you have additional remedies available.

For questions about your rights or for additional assistance, you may contact the Oklahoma consumer assistance program at:

Oklahoma Insurance Department
3625 NW 56th Street
Oklahoma City, OK 73112-4511
http://www.ok.gov/oid/Consumers/index.html
Telephone: 1-800-522-0071 or 405-521-2828

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Member Handbook to which this amendment is attached will remain in full force and effect.

Chief Executive Officer of BlueLincs HMO

1215 South Boulder • P.O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Group Master Agreement and the Member Handbook to which this amendment is issued for attachment are amended as set forth below:

A. AMENDMENT RESPECTING DEPENDENT ELIGIBILITY

Wherever used in the Group Health Plan, "Dependent child" means a natural child, a stepchild, an adopted child or child Placed for Adoption (including a child for whom the Subscriber or spouse is a party in a legal action in which the adoption of the child is sought), under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child not listed above who is legally and financially dependent upon the Subscriber or spouse is also considered a Dependent child under the Group Health Plan provided proof of dependency is provided with the child's application.

If the Group Health Plan contains provisions extending coverage for Dependents beyond their 26th birthday (e.g., for full-time students), then those provisions shall remain in effect. A Dependent child who is medically certified as disabled and dependent upon the Subscriber or his/her spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

B. AMENDMENT RESPECTING LIFETIME MAXIMUMS

Coverage under the Group Health Plan shall not be subject to any ***dollar*** Lifetime Maximum, including the separate ***dollar*** Lifetime Maximum previously applicable for treatment of autism and autism spectrum disorders.

C. AMENDMENT RESPECTING BENEFIT PERIOD MAXIMUMS

The Benefit Period ***dollar*** maximums shown in the Schedule of Benefits or in any amendment or endorsement issued thereto are amended as set forth below:

1. Durable Medical Equipment — The Benefit Period ***dollar*** maximum is hereby removed.
2. Services Related to Treatment of Autism or Autism Spectrum Disorders — The Benefit Period ***dollar*** maximum is hereby removed. The age limit for treatment of autism or autism spectrum disorders is hereby removed. The following limitations shall apply:
   - **Members under age six** shall be entitled to a combined maximum of 390 visits for Physical Therapy, Occupational Therapy and Speech Therapy per Benefit Period.
   - **Members age six and older** are subject to the limitations for Outpatient Speech Therapy. Physical Therapy and Occupational Therapy visits specified under "**Special Services**" in the Schedule of Benefits.

Other Covered Services, as specified in the Schedule of Benefits or in any amendment issued thereto, related to treatment of autism or autism spectrum disorders shall not be subject to a Benefit Period maximum.

D. AMENDMENT RESPECTING PREVENTIVE CARE SERVICES

Benefits will be provided for the following Covered Services, and Participating Provider services will not be subject to Deductibles, Copayments and/or Coinsurance or dollar maximums:

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
3. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
4. with respect to women, such additional preventive care and screenings, not described in item 1 above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this Benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The Preventive Care Services described in items 1 through 4 above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, Members may access the website at www.bcbsok.com or contact customer service at the toll-free number listed on their identification card.

Examples of Covered Services included are routine annual physicals, immunizations, well-child care, cancer screening mammograms, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services, healthy diet counseling and obesity screening/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Covered Services ***not*** included in items 1 through 4 above may be subject to Deductible, Copayment, Coinsurance and/or dollar maximums.

E. AMENDMENT RESPECTING EMERGENCY CARE SERVICES

Emergency Care Services rendered by a non-Participating Provider shall be paid at the same benefit level applicable to Participating Providers. Notwithstanding anything in the Group Health Plan to the contrary, for out-of-network Emergency Care Services rendered by non-Participating Providers, the allowable charge shall be equal to the greatest of the following three possible amounts—not to exceed billed charges:

1. the median amount negotiated with network or Participating Providers for the Emergency Care Services furnished;
2. the amount for the Emergency Care Services calculated using the same method the Group Health Plan generally uses to determine payments for out-of-network Provider services, but substituting the in-network, participating or contracting cost-sharing provisions for the out-of-network or non-Participating Provider cost sharing provisions; or
3. the amount that would be paid under Medicare for the Emergency Care Services.

Each of these three amounts is calculated excluding any network or Participating Provider Copayment or Coinsurance imposed with respect to the Member.

F. **AMENDMENT RESPECTING MEMBER APPEAL RIGHTS**

The External Review (Level III) appeals process is amended by the addition of the following provisions:

For questions or assistance regarding the right to an external review by an independent review organization, the Member may call the customer service number shown on the Identification Card. Members may also contact the Oklahoma Insurance Department at the following address:

Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152-3408
1-800-522-0071 (Oklahoma only)
405-521-2991

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Agreement and Member Handbook to which this amendment is attached will remain in full force and effect.

For Agreements in effect on or after September 23, 2010, this amendment is effective on the Agreement Effective Date or Agreement Date Anniversary.

BlueLincs HMO

Chief Executive Officer

Blue Cross and Blue Shield of Oklahoma

1400 S. Boston • PO Box 21128
Tulsa, OK 74121-1128
(918) 561-9933

3401 N.W. 63rd • PO Box 60545
Oklahoma City, OK 73146-0545
(405) 841-9777

1-800-580-6202

www.bcbsok.com

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